Submitter : Ms. Otilia Poltarack **Date & Time:** 09/24/2004 12:09:48

Organization : Ms. Otilia Poltarack

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.
Thank You. Sincerely, MS. Otilia Poltaracm MA#4184

CMS-1429-P-3601

Submitter : Ms. Laura Benson **Date & Time:** 09/24/2004 12:09:18

Organization : Princeton Neuromuscular Massage Therapy Clinic

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear Sir/Madam,

I want to strongly ask that you NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a doctors prescription or under their supervision. A physician has the right to delegate the care of his or her patients to trained individuals whom they deem knowledgeable and trained in the protocols to be administered. Medicare and private payers have always relied upon the professional judgement of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients. Secondly to mandate that only physical therapist, occupational therapists, speech and language pathologists can provide "incident to" outpatient therapy services would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services. Thank you in advance for your vote oppossing this policy that will most certainly restrict the physicians ablities to utilize their judgement and limit those who could provide ANY "incident to" service. In addition thank you for not supporting exclusivity to providers of therapy services and deminishing from the States right to license and regulate the allied health care professions. Sincerely, Laura Benson, L.M.T., C.N.M.T.

Submitter : Dr. John C. Gray **Date & Time:** 09/24/2004 12:09:03

Organization : Dr. John C. Gray

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Services billed as Physical Therapy should only be reimbursed if those services are performed by a licensed Physical Therapist or a licensed Physical Therapy Assistant. To do otherwise may result in harm to the consumer due to untrained personnel performing duties they are not licensed to perform. This will also result in a decrease in consumer confidence for the profession of Physical Therapy as consumers assume that anyone can perform Physical Therapy interventions.

CMS-1429-P-3603

Submitter : Mr. Gregory Jackson **Date & Time:** 09/24/2004 12:09:46

Organization : American Physical Therapy Association

Category : Physical Therapist

Issue Areas/Comments

Issues 10-19

SECTION 952

I, as a Physical Therapist who hold a Masters Degree in the field, strongly support CMS's proposal that individuals who furnish physical therapy services in physician's offices MUST be graduates of an accredited professional physical therapist program. PTs and PTAs are the ONLY caregivers who have the appropriate training to provide PT services. Graduating PTs are now required to hold master's degrees in the field in order to be eligible for licensure. Many weeks of specific clinical affiliations are requisite to all PT programs. Exercise physiologists and athletic trainers do NOT have the scope of knowledge of disease processes and their implications, to make sound therapy related decisions regarding treatment plans. These unqualified personnel are likely to not know many of the CONTRAINDICATIONS of therapy treatments, thus potentially harming their clients.

Submitter : Dr. Blake Bergeon **Date & Time:** 09/24/2004 01:09:33

Organization : Rehabilition Associates of MidMichigan

Category : Physician

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

CMS-1429-P-3604-Attach-1.doc

Blake A. Bergeon, MD
555 W. Wackerly St.
Midland, MI 48642

September 12, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- "Incident to" has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY "incident to" service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. ***It is imperative that physicians continue to make decisions in the best interests of the patients.***

- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.

- Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor's or master's degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master's degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

- To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide "incident to" outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide "incident to" outpatient therapy in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. ***In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.***

- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Blake Bergeon, MD

Submitter : Miss. Donna Wesley **Date & Time:** 09/24/2004 01:09:53

Organization : Miss. Donna Wesley

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See Attached Letter

CMS-1429-P-3605-Attach-1.doc

Donna E. Wesley
414 Oak Road
Fulton, MS 38843

September 23, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel

expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Donna E. Wesley, ATC/LAT, M.S.

414 Oak Road

Fulton, MS 38843

Submitter : Catherine Thompson **Date & Time:** 09/24/2004 01:09:17

Organization : Catherine Thompson

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Massage therapy is a necessary service physicians and other practitioners should be allowed to provide. A physical therapist is not a massage therapist and a massage therapist is not a physical therapist. They have aspects in common. It is a disservice to both professions and the unique qualities they offer to promote one over the other. The choice should be left to the patient and the physician/doctor in their unique situation. Please do not take this choice away. Each has something unique to offer. Please do not bring in mediocrity into the healthcare system when these unique modalities are historically separated FOR A REASON. They are not the same. It is not fair to the consumer, it's disrespectful to physicians that are trying to offer good care and it's not fair to the dedicated massage professionals or the physical therapists. Physical therapists did not go to school to be massage therapists. They may use similar techniques but their intention and approach is different. I have had both physical therapy to recover from injuries - and various specialties of massage for my well-being to address various issues. I experienced both experiences as being dramatically different. You cannot and should not substitute one for the other.

Submitter : Bonnie Dye **Date & Time:** 09/24/2004 01:09:22

Organization : FSMTA

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

As a medical massage therapist working in an outpatient physical therapy clinic, I have been privileged to work on patients of Medicare age both in clinical and private practice. The benefits they hve received great benefits from this type of therapy. I do not want physical therapists to be the only health care professionals allowed to provide medically related care to physicians' patients. I do not "do" physical therapy in my work, and the PT's I have worked with say they prefer qualified massage therapists to provide that service to patients so that they can attend to the areas that require their expertise. Most likely it would be a "task" assigned to a physical therapy assistant and many are not qualified to do specialized massage work. Massage Therapists are specialists. I had 700 hours of initital training and have to complete many more hours each year to maintain my license. Therapists who work under the supervision of physicians take pride in the Continuing Education coursework they pursue. And that coursework has nothing to do with the type of continuing education that a PT would be taking. Please keep this work covered under the care of our older citizens. The physical therapy and massage therapy work in conjunction with each other very well. Please allow services to be covered by licensed medical massage therapy and not restricted to physical therapists. Thank you for reading this message.

Submitter : Ms. T.G. Gilliam **Date & Time:** 09/24/2004 01:09:54

Organization : American Massage Therapy Assoc.

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I ask that you NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. ALL qualified health care providers should be allowed to provide services to patients with a
physicians prescription or under their supervision.
Thank you

Submitter : Dr. Gary Dillehay **Date & Time:** 09/24/2004 01:09:36

Organization : Society of Nuclear Medicine

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Attached please find our comments.
Thank you

Department of Health and Human Services
Centers for Medicare and Medicaid Services (CMS)
Offices of Strategic Operations and Regulatory Affairs

The attachment to this document is not provided because:

1. The document was improperly formatted.
2. The submitter intended to attach more than one document, but not all attachments were received.
3. The document received was a protected file and can not be released to the public.
4. The document is not available electronically at this time. If you like to view any of the documents that are not posted, please contact CMS at 1-800-743-3951 to schedule an appointment.

Submitter : Dr. Kristinn Heinrichs **Date & Time:** 09/24/2004 01:09:24

Organization : Dr. Kristinn Heinrichs

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please refer to the attached file

CMS-1429-P-3610-Attach-1.pdf

Peak Sports Performance International
excellence in sports medicine

September 23, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Dear Sir/Madam:

Re. Proposed Changes: Federal Register, vol 69, No. 150. August 4, 2004, pp. 47550-47551.
Section IV.A.1. Outpatient Therapy Services Rendered Incident To
CMS-1429-P - Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

I have reviewed the proposed CMS changes noted above and I am writing to express my concerns over these changes, both as a licensed physical therapist and licensed athletic trainer, as well as exercise physiologist for 25 years. In addition, I speak from the perspective of having been a program director for an entry-level athletic training education program and a faculty member in a physical therapy program.

During your deliberations, I would ask you to consider the following points:

- Under the current regulations, in many states (Georgia included), rehabilitation services may be provided by unlicensed individuals as delegated by the attending physician. There is no public assurance that many of these individuals indeed possess the academic training and knowledge in anatomy, physiology, neuromuscular re-education. Under the current policy it is possible for a high school student or another individual with no training in the aforementioned areas to provide services in a physician's office without the physician actually observing the provision of these services. In some cases, the improper application of physical modalities (e.g. ultrasound, traction, iontophoresis, pulsed electromagnetic fields, laser) or neuromuscular re-reduction by an unqualified individual poses a very real and significant threat of harm to the patient.
- Certified athletic trainers (ATCs) are licensed health care professionals whose practice domain includes individuals who are physically active and who may be injured as a result of participating in physical activities. As such, the academic curricula of the certified athletic trainer includes some overlapping competencies, including therapeutic modalities (as mentioned above) and neuromuscular rehabilitation applied primarily to the orthopedic, sports, and musculoskeletal areas. However, the educational and accreditation standards do not include formal educational training for the certified athletic trainer in the areas of neuropathophysiology, pathophysiology, internal medicine outside the realm of sports, geriatric physiology, cardiovascular physiology to the extent received by the physical therapist. Therefore, the certified athletic trainer might be an appropriate provider choice for the Medicare patient who is injured during participation in a community athletic event, but would certainly not be the provider of choice for a Medicare patient who demonstrated a significant cardiac history participating in the same event. The certified athletic trainer who has graduated from an accredited athletic training professional program would be well-qualified to furnish services in sub-populations of the Medicare population but this individual would have no formal training in providing

Kristinn I. Heinrichs, phd, pt, scs, atc, cscs
p.o. box 61281 savannah, georgia USA 31420-61281 phone/fax 1-912-303-0711
e-mail: kheinrichs@sportsperformance.org www.sportsperformance.org

services to, for example, the complicated diabetic patient, amputee rehabilitation, patients with rheumatological disorders, spinal-cord injured patients, brain-injured patients (stroke, etc.), cardiorespiratory patients, or cardiac rehabilitation patients, for example. Physical therapists, occupational therapists, and speech-language pathologists receive formal training in adult rehabilitation for ALL these pathologies while the practice domain of the certified athletic trainer is limited to the musculoskeletal domain. In other areas mentioned above, while the certified athletic trainer has graduated from an accredited professional program (effective in 2004 this is a requirement to sit for the certification examination) and in many states is licensed, treatment of these Medicare beneficiaries falls outside their practice domain.

- Although research has demonstrated no difference in the care provided by physical therapists and certified athletic trainers, these findings can't be generalized to the entire Medicare population; rather these findings are limited to the area of musculoskeletal disorders.
- Many physicians may argue that referring patients outside their own offices result in additional time delays and expense or that they would be forced to perform rehabilitation services themselves. This is simply not the case. In fact, in Georgia, rehabilitation services provided in physician offices may be performed by unlicensed personnel.
- Medicare reimbursement should be based on quality control. Eliminating reimbursement of services provided by unlicensed personnel who are unqualified to provide safe and effective care to the Medicare will ultimately be more cost-effective as the patient is assured they are receiving care from a licensed health care professional who has the necessary academic knowledge and clinical skills to effectively treat the condition.

In conclusion, I favor the institution of the changes proposed by the CMS. Medicare reimbursement should be made only for services provided by licensed and professional individuals who possess the requisite formal training in the global provision of rehabilitation services.

Sincerely,

Dr. Kristinn Heinrichs, PhD, PT, SCS, ATC, CSCS
Diplomate, American Board of Physical Therapy Specialties (Sports)

Kristinn I. Heinrichs, phd, pt, scs, atc, cscs
p.o. box 61281 savannah, georgia USA 31420-61281 phone/fax 1-912-303-0711
e-mail: kheinrichs@sportsperformance.org www.sportsperformance.org

Submitter : Ms. Maryellen Walsh **Date & Time:** 09/24/2004 01:09:43

Organization : Self--senior, consumer

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I write about the extremely unfair reimbursement plan now existing in Santa Cruz County in CA. Our neighboring county, Santa Clara, pays doctors 25% more. It's hard to recruit doctors here and it interfers with patient care.
Please bring us up to parity with other Bay Area Counties.
Thank you.
Maryellen Walsh and Mac Small

Submitter : Michele Porzel **Date & Time:** 09/24/2004 01:09:52

Organization : Intuitive Healing Center

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I ask you not to pass this policy (Issues 20-29) whereby a physician can only refer 'incident to' services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision. I am a Massage Therapist, a member of AMTA and hold the national certification, NCBTMB. Clients have the right to a greater range of services than what physical therapists can provide. I often see that clients need relaxation and opening of tissue before exercises that are usually prescribed. Please make sure that the clients options are not limited to physical therapists. Thanks!

CMS-1429-P-3613

Submitter : Dr. Gary Dillehay **Date & Time:** 09/24/2004 01:09:37

Organization : Society of Nuclear Medicine

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Attached please accept our comments. Please send us an e-mail to confirm that you have received the attachment as we have tried this two times now and we are not sure that the attachment has been received by CMS.
Thank you
Denise Merlino for Dr. Gary Dillehay
dmerlino@snm.org

CMS-1429-P-3613-Attach-1.doc

1850 Samuel Morse Drive
Reston, VA 20190-5316
Tel: 703.708.9000
Fax: 703.708.9015
www.snm.org

September 23, 2004

Submitted Electronically: http://www.cms.hhs.gov/regulations/ecoments

Administrator Mark McClellan
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
ROOM 445-G
200 Independence Avenue, S.W.
Washington, DC 20201

ATTN: FILE CODE CMS-1429-P

Re: Medicare Program; Revisions to Payment Policy under the Physician Fee Schedule for Calendar Year 2005; Proposed Rule

Dear Administrator McClellan:

The Society of Nuclear Medicine (SNM) representing more than 14,000 physicians, physicists, scientists, pharmacists and nuclear medicine technologists, appreciates the opportunity to comment on the August 5, 2004, (69 Fed. Reg. 47487) proposed rule on revisions to payment policies under the physician fee schedule of the Medicare Program.

The SNM offers comments and recommendations on the following topics addressed in this final rule:

1. Eliminate G PET codes and adopt 2005 CPT codes
2. Payment for Part B Drugs & Radiopharmaceuticals;
3. Practice Expense;
4. Drug Administrations; and
5. Medicare Payment Update

Eliminate G PET Codes and Adopt 2005 CPT Codes

For many years CMS has chosen to implement complex G series HCPCS codes for PET procedures, in spite of the availability of CPT codes for the same procedures. G codes for PET (cardiac procedures) were originally created to track and monitor the clinical use of PET. We are not aware of the use of those G codes for that purpose, nor are we convinced that further tracking and data collection of this type is meaningful or useful.

There currently exist CPT codes for all current clinical PET procedures:
Heart
CPT 78459 *Myocardial imaging, positron emission tomography (PET) metabolic evaluation*
CPT 78491 *Myocardial imaging, positron emission tomography (PET) perfusion; single study at rest or stress*
CPT 78492 *Myocardial imaging, positron emission tomography (PET) perfusion; multiple studies at rest and /or stress*
Brain
CPT 78608 *Brain imaging, positron emission tomography (PET); metabolic evaluation*
CPT 78609 *Brain imaging, positron emission tomography (PET); perfusion evaluation*
Tumor
CPT 78810 *Tumor imaging, positron emission tomography (PET), metabolic evaluation.*

Effective January 1, 2005 CPT will publish new and refined PET codes specifically for tumor imaging, which we believe better meet the provider and global payer needs.

G Codes for PET were introduced by CMS in 1995 for Cardiac PET studies. It was our understanding that they were to be used to evaluate the use of PET in cardiac disease. We are unaware of any review of that data by CMS. As shown in Addendum A listed at the end of this letter there has been a continual restructuring of PET codes with additions and deletions each year. They have primarily represented the INDICATIONS for the use of PET in patients for oncological, cardiological and recently neurological disease. CPT codes represent the PROCEDURES themselves.

Over the past several years, CMS with the AMA RUC has established a process for constructing the costs to provide those procedures. CPT codes are used by all providers for billing of PET studies, except for Medicare patients. We believe that using the CPT codes for the Medicare patients will facilitate implementation for both the CMS as well as for the providers. CMS has developed National Coverage Determinations (NCD) for many established procedures. CMS can oversee the coverage determination without the use of G codes.

Carriers are familiar with implementing NCDs by identifying ICD 9 CM codes and implementing them in their local coverage determinations. As stated in the recently published coverage decision for Alzheimer requirements, “The referring and billing providers(s) have documented the appropriate evaluation of the Medicare Beneficiary…” is sufficient to validate compliance as necessary. Use of G codes does not ensure compliance. An initial algorithm for ICD 9 CM codes associated with the current specific G codes can be found in Addendum B.

The SNM urges CMS **to discontinue use of these** PET G series HCPCS codes and instruct providers to use the available CPT codes. The SNM has listed and cross walked all current PET G codes to their respective CPT codes in Table 1. **The SNM recommends that CMS use the CPT codes for all PET studies *and discontinue all PET G series HCPCS codes effective January 1, 2005.*** Provider management and use of the G series HCPCS codes are administratively burdensome, creating cumbersome charge description masters based on a variety of payers. Private payers often use the RUC approved and CMS published RVUs for establishing payment rate. Therefore publishing these values are important not only for Medicare beneficiaries but are equally important for private payers use.

In January 2005 there will be three new oncology pet CPT codes to replace the current CPT code 78810 and three "PET/CT" codes for fusion localization imaging. We **recommend that CMS adopt the recent RUC approved values for all the Oncology CPT PET codes and update Medicare published relative values for each professional, technical and global payment rates for these procedures.** We do not recommend that CMS leave payment setting for Oncology PET to carrier discretion, which has lead to inconsistent payment rates across the country.

We propose a meeting with the appropriate CMS staff to discuss these new PET Oncology CPT codes and their implementation in January 2005 especially in regard to the PET and PET/CT technology.

Table 1 PET G series HCPCS codes and PET CPT Code Crosswalk

CPT Code	Long Description	G series PET HCPCS Code	Long Description or Comments
78459	*Myocardial imaging, positron emission tomography (PET) metabolic evaluation*	G0230	PET imaging; metabolic assessment for myocardial viability following inconclusive SPECT study
78491	*Myocardial imaging, positron emission tomography (PET) perfusion; single study at rest or stress*	G0030	PET myocardial perfusion imaging (MPI), following previous PET, G0030-G0047); single study, rest or stress (exercise and/or pharmacologic)
		G0032	PET MPI, (following rest SPECT, 78464); single study, rest or stress (exercise and/or pharmacologic)
		G0034	PET MPI, (following single study, rest or stress (exercise and/or pharmacologic)
		G0036	PET MPI, (following single study, rest or stress (exercise and/or pharmacologic)
		G0038	PET MPI, (following single study, rest or stress (exercise and/or pharmacologic)
		G0040	PET MPI, (following single study, rest or stress (exercise and/or pharmacologic)

		G0042	PET MPI, (following single study, rest or stress (exercise and/or pharmacologic)
		G0044	PET MPI, (following single study, rest or stress (exercise and/or pharmacologic)
		G0046	PET MPI, (following single study, rest or stress (exercise and/or pharmacologic)
78492	*Myocardial imaging, positron emission tomography (PET) perfusion; multiple studies at rest and/or stress*	G0031	PET myocardial perfusion imaging (MPI), following previous PET, G0030-G0047); multiple studies, rest or stress (exercise and/or pharmacologic)
		G0033	PET MPI, (following rest SPECT, 78464); multiple studies, rest or stress (exercise and/or pharmacologic)
		G0035	PET MPI, (following multiple studies, rest or stress (exercise and/or pharmacologic)
		G0037	PET MPI, (following multiple studies, rest or stress (exercise and/or pharmacologic)
		G0039	PET MPI, (following multiple studies, rest or stress (exercise and/or pharmacologic)
		G0041	PET MPI, (following multiple studies, rest or stress (exercise and/or pharmacologic)
		G0043	PET MPI, (following multiple studies, rest or stress (exercise and/or pharmacologic)
		G0045	PET MPI, (following multiple studies, rest or stress (exercise and/or pharmacologic)
		G0047	PET MPI, (following multiple studies, rest or stress (exercise and/or pharmacologic)
78608	*Brain imaging, positron emission tomography (PET); metabolic evaluation*	G0336	PET Imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs fronto-temporal dementia
		G0229	PET imaging; metabolic brain imaging for pre-surgical evaluation of refractory seizures
78609	*Brain imaging, positron emission tomography (PET); perfusion evaluation*		
78810	*Tumor imaging, positron emission tomography (PET), metabolic evaluation* Effective January 1, 2005 Six New CPT codes will	G0125	PET imaging regional or whole body; single pulmonary nodule
		G0210	PET imaging whole body; diagnosis; lung cancer, non-small cell
		G0211	PET imaging whole body, initial staging; lung cancer, non-small cell (Replaces G0126)

	replace this single code to describe tumor imaging with PET and PET/CT technology.	G0212	PET imaging whole body, restaging; lung cancer; non-small cell (Replaces G0126)
		G0213	PET imaging whole body; diagnosis; colorectal (Replaces G0163)
		G0214	PET imaging whole body; initial staging; colorectal (Replaces G0163)
		G0215	PET imaging whole body; restaging; colorectal cancer (Replaces G0163)
		G0216	PET imaging whole body; diagnosis; melanoma (Replaces G0165)
		G0217	PET imaging whole body; initial staging; melanoma (Replaces G0165)
		G0218	PET imaging whole body; restaging; melanoma (Replaces G0165)
		G0219	PET imaging whole body; melanoma for non-covered indications
		G0220	PET imaging whole body; diagnosis; lymphoma (Replaces G0164)
		G0221	PET Imaging whole body; initial staging; lymphoma (Replaces G0164)
		G0222	PET Imaging whole body; restaging, lymphoma (Replaces G0164)
		G0223	PET imaging whole body or regional; diagnosis; head and neck cancer; excluding thyroid and CNS cancers
		G0224	PET imaging whole body or regional; initial staging; head and neck cancer; excluding thyroid and CNS cancers
		G0225	PET imaging whole body or regional; restaging; head and neck cancer; excluding thyroid and CNS cancers
		G0226	PET imaging whole body; diagnosis; esophageal cancer
		G0227	PET imaging whole body; initial staging; esophageal cancer
		G0228	PET imaging whole body; restaging; esophageal cancer
		G0231	PET, whole body, for reoccurrence of colorectal or colorectal metastases cancer; gamma cameras only
		G0232	PET, whole body, for reoccurrence of lymphoma; gamma cameras only
		G0233	PET, whole body, for reoccurrence of melanoma; gamma cameras only
		G0234	PET, regional or whole body, for solitary pulmonary nodule following CT or for initial staging of pathologically diagnosed nonsmall cell lung cancer; gamma cameras only

		G0252	PET imaging, full & partial-ring PET scanner only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (eg, initial staging of axillary lymph nodes)
		G0253	PET imaging for breast cancer, full and partial-ring PET scanners only, staging/restaging of local regional recurrence or distant metastases (ie, staging/restaging after or prior to course of treatment
		G0254	PET imaging for breast cancer, full and partial-ring PET scanners only, evaluation of response to treatment, performed during course of treatment
		G0296	PET imaging, full & partial-ring PET scanner only, for restaging of previously
		G0330	PET Imaging initial dx cervical CA
		G0031	PET Imaging restaging ovarian CA

Payment for Part B Drugs & Radiopharmaceuticals

The SNM is pleased that Congress has taken measures to reform payment rates for physicians and covered outpatient drugs, specifically that radiopharmaceuticals are covered outpatient drugs. **The SNM supports alternative payment methodologies for drugs and radiopharmaceuticals which adequately cover all providers' costs including transportation, waste and spoilage.** The new average sales price (ASP) payment methodology represents a major change in drug payment policy. We are concerned that this policy may cause unintended limited access to Medicare beneficiaries to those facilities with lower volume or geographically distant from central radiopharmacies. Additionally, since radiopharmaceuticals are "unique drugs" with higher transportation and waste considerations we urge CMS to account for these variations appropriately.

The SNM looks forward to working closely with CMS staff offering our assistance and nuclear medicine expertise and knowledge to clarify crosswalk and translation issues (ie conversions from mCi to uCi or per dose) to achieve and establish appropriate reimbursement for radiopharmaceuticals under the new statutory framework. This issue is of paramount importance to the nuclear medicine community, and key to continued availability of the radiopharmaceuticals that are the fundamental component of our specialty. To this end, we remain committed to offering education and assistance to CMS staff regarding radiopharmaceuticals.

Practice Expense

The SNM appreciates and commends CMS for recognizing and adjusting the crosswalk for **CPT 78070 Parathyroid Imaging** as this procedure involves multiple imaging sessions which were not

previously recognized in the practice expense calculations. If a CPT code involves multiple imaging sessions, the practice expense related to the imaging portion should be adjusted to reflect the number of imaging sessions.

The SNM agrees with the CMS proposal to delete the current **"room" designation** for the radiopharmaceutical receiving area and in its place list separately the equipment necessary for each procedure as individual line items because we agree that there is not a standard configuration for the rooms across the nuclear medicine CPT codes.

The SNM has reviewed the **CMS list of PEAC approved CPT codes** and we find some recently approved nuclear medicine CPT codes missing from the CMS list. Those missing codes and PEAC approved date are listed in the table below:

NM Codes	Description	**SNM Comments**
78160	Plasma radioiron disappearance (turnover) rate	March 2004 PEAC minutes refined
78162	Radioiron oral absorption	March 2004 PEAC
78170	Radioiron red cell utilization	March 2004 PEAC
78172	Chelatable iron for estimation of total body iron	March 2004 PEAC
78206	Liver image (3D0 with flow	January 2004 PEAC
78282	Gastrointestinal protein loss	March 2004 PEAC
78350	Bone density (bone mineral content) study, one or more sites; single photon absorptiometry	March 2004 PEAC
78351	Bone density (bone mineral content) study, one or more sites; dual photon absorptiometry, one or more sites	March 2004 PEAC
78455	Venous thrombosis study (eg, radioactive fibrinogen)	March 2004 PEAC
78465	Heart Image (3D), Multiple	January 2002
78600	Brain Imaging, LTD Static	January 2004
78607	Brain Imaging, (3D)	January 2004
78647	Cerebrospinal Fluid Scan	January 2004
78803	Tumor Imaging (3D)	January 2004
78807	Nuclear Localization/Abscess	January 2004

79300	Interstitial radioactive colloid therapy	Revised PEAC April 2004
79403	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion	Revised PEAC April 2004
79420	Intravascular radiopharmaceutical therapy, particulate	Revised PEAC April 2004

The SNM appreciates the opportunity to submit **nuclear medicine equipment cost clarification** and quotes as requested and identified in Table 2 labeled Equipment Items Needing Specialty Input for Pricing and Proposed Deletions. The SNM wants to assure CMS receives correct and current pricing information and accordingly will continue to dialogue with CMS in this area. Obtaining the cost, source and documentation information requested by BMS for these equipment items is a difficult and time consuming task, and all information is not readily available. The SNM will continue to work with CMS to obtain the correct pricing information for the items listed in Table 2 and requests an extension to allow additional time to collect and submit this information. We will attach a copy of the reference source and quote at the end of this letter which was available for these comments.

CMS Table 2

Code	2005 Description	Price	*CPT code(s) associated with item	SNM Comments
E53005	Collimator, cardiofocal set	29,990.00	78206, 78607, 78647, 78803, 78807.	Pending requested Extension
E53034	Densitometry unit, whole body, DPA.	65,000.00	78351……..	Pending requested Extension
E53032	Densitometry unit, whole body, SPA.	22,500.00	78350	Pending requested Extension
E53036	Detector (probe)	14,000.00	78455	Pending requested Extension
E91008	IVAC Injection Automatic Pump.	2,500.00	78206, 78607, 78647, 78803, 78807.	Pending requested Extension
E51076	Well counter……. …….		78160-72, 78282	Pricing and Quotes supplied at the end of these comments

The SNM appreciates the contractor suggestion and CMS efforts in the proposal to assign equipment categories for easier identification and sorting of items. CMS proposes to assign equipment into one of the following seven categories: documentation, laboratory, scopes, radiology, furniture, room lanes, and other equipment. The SNM is concerned with this limited number of categories. Nuclear Medicine crosses over several specialties. The current descriptions are not clear as to which designations are diagnostic (imaging and non - imaging) and therapeutic nuclear medicine equipment would reside. **We recommend that "Radiology" be changed to "Imaging Equipment," and "other equipment" be changed to "non-imaging equipment" to be inclusive of these modalities.**

CMS proposes to establish a separately billable supplying fee, payment rate of $10.00 for each prescription; effective January 1, 2005 this supplying fee would be allowable for immunosuppressive drugs, oral anticancer chemotherapeutic drugs, and an oral anti-emetic drugs as part of an anticancer chemotherapeutic regimen. The SNM supports the establishment of a supplying fee.

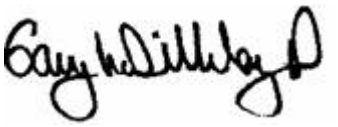
Medicare Payment Update

The SNM appreciates the efforts made by Congress and the CMS to prevent the previously impending negative 4% conversion factor reductions. The SNM is concerned, as are other professional societies that beginning in 2006 physicians will face four years of deep cuts to recoup the costs of the 2004 and 2005 increases unless changes are made to the physician formula. The SNM is committed to working with professional societies and CMS to evaluate and correct this formula to ensure that such dramatic cuts may be avoided in 2006.

As mentioned earlier in these comments, the SNM and other interested professional societies would like to meet with CMS staff regarding the new PET and PET/CT codes. We are hoping for a smooth transition. We would be happy to assist CMS in the implement of these new codes.

Again, the SNM appreciates the opportunity to comment on this proposed rule to the CMS. Should you find it appropriate to do so, the SNM is ready to discuss any of its comments on the above issues. Please contact the Society of Nuclear Medicine coding and reimbursement advisor, Denise A. Merlino at dmerlino@snm.org, or at 781-435-1124.

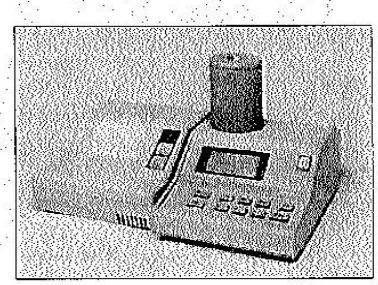
Respectfully Submitted,



Gary Dillehay, M.D.
Chairman, Coding and Reimbursement Committee

Cc: Terry Kay
Ken Simon
Edith Hambrick
Carolyn Mullen
SNM Coding and Reimbursement Committee
SNM Board of Directors
Kenneth McKusick
Denise Merlino

CAPRAC® WIPE TEST WELL COUNTER



FEATURES
- Meets NRC/Agreement State regulations, including new regulations in 10 CFR Part 35.315
- Simple to operate
- NaI drilled-well crystal detector
- Performs wipe test in 6 seconds
- 6-channel, pulse-height analyzer
- Preliminary isotope identification through gamma spectroscopy
- Accepts and stores individual trigger levels for different areas (hot lab, patient rooms, unrestricted, sealed-source leak tests, etc.)
- Optional printer for hard-copy archives wipe-test results; prints photon-energy histograms
- Counts which exceed trigger levels are printed in red

FASTER, MORE ACCURATE THAN ANY WELL COUNTER ON THE MARKET

Don't worry about meeting the new regulations in 10 CFR Part 35.315 (200 dpm requirements for unrestricted areas, patient rooms and incoming packages). The CAPRAC Wipe-Test Counter handles all of them.

Measure for measure, no other well counter offers the speed, accuracy and complete range of built-in features provided by the compact CAPRAC. It performs a wipe test in just 6 seconds (for 1 nCi) and detects incredibly low levels of activity with the accuracy only a NaI drilled-well crystal detector can provide.

The CAPRAC can also serve as a single-well gamma counter in departments that do not need multi-sample chambers. User-defined protocols, trigger levels, and counting times are a "snap". A 6-channel pulse-height analyzer enables built-in gamma spectrosocpy. Definable conversion factors for specific radionuclides enable the CAPRAC to calculate results in cpm, dpm, nCi, cps, dps, or kBq. The CAPRAC also displays photon-energy histograms.

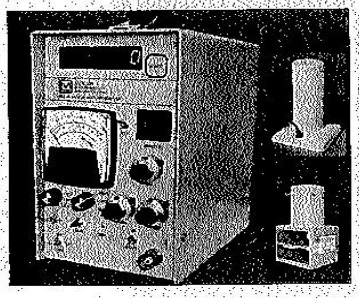
The CAPRAC is engineered and built for years of consistent, reliable performance and is Curie or Becquerel, selectable. The unit has automatic background subtraction and self-diagnosis programs for systems testing with optimized signal-to-noise ratio. It includes a lead outer shield (1.3 cm thick) with optional auxiliary shield available.

SPECIFICATIONS

Counter: 16.5 lbs. 7.25" (18.4 cm) wide, 11.5" (29.2cm) deep, 10.3" (26.2 cm) high
NaI (Tl) crystal detector
Power: Standard: 115 VAC 50/60 Hz 0.1A
Optional: 220V 50/60 Hz 0.05A
Measurement periods: 6, 20, 60, 180, 600, 1800 sec
Radiation shield: 0.5" (1.3 cm) lead outer shield
Counting rate: cpm, kcpm, (Ci) cps, kcps (Bq)
Counting channels:
1 = 15-100 keV
2 = 100-200 keV
3 = 200-400 keV
4 = 400-660 keV
5 = 660-800 keV
6 = >800 keV

CAPRAC	Wipe Test Counter	**$3,450.00**
CAPRAC-R	Wipe Well Counter with Remote Chamber	**$3,995.00**
5430-0058	CAPRAC Printer	**$412.00**
9282-0009	CAPRAC Paper (12 rolls/box)	**$35.00**
006-350	Wipe Test Smears	**$65.00**
5420-2072	Auxiliary Shield for CAPRAC	**$186.00**
5420-2116	Auxiliary Shield for CAPRAC-R	**$210.00**

LUDLUM MODEL 2200 PORTABLE SCALER RATEMETER



The Model 2200 Portable Scaler Ratemeter is a self contained counting instrument designed for operation with scintillation, proportional or GM detectors. When coupled with the 187-243 Well Counter, the meter is suitable for performing Wipe Test counting, Schilling Test and any general lab work. Power is derived from either 4 "D" batteries or line power. Electronics contain a charging circuitry for use with rechargeable lithium batteries. The unit is complete with a charge sensitive pre-amplifier, linear amplifier, electronic timer and detector high voltage power supply. A single channel analyzer is also featured in this unit. The SCA may be switched in or out, allowing gross or window counting. Ten turn controls are supplied for threshold, window, and high voltage.

SPECIFICATIONS: ***Scaler/ Ratemeter***
Indicated Use: Single-channel analyzing, gross sample counting
Compatible Detectors: Scintillation, GM, proportional
Scaler: 6-digit LED display with dimmer control; Range: 0- 999,999 counts (controlled by "COUNT" button)
Scaler linearity: Reading within,,2% of true value
Timer: Thumb wheel adjustment from 0 -999 minutes with selectable divisions of x 0.1 and x1
Ratemeter: 0 -500,000 cpm total range
Meter: 2.5" arc (6.4 cm), 1 mA movement, analog
Meter Dial: 0- 500 cpm, 0- 2.5 kV, Battery Test
Multipliers: x1, x10, x100, x1000
Linearity: Reading within" 10% of true value with detector connected
Response: Toggle switch for FAST (4 sec.) or Slow (22 sec.) from 10% to 90% of final reading
Zero: Push button to zero meter
High Voltage: Adjustable from 200- 2500 volts (will support 60 megohm scintillation loads)
Threshold: Voltage sensitive, adjustable from 1.00- 10.00
Window: Adjustable from 0- 10.0 above the threshold setting (can be enabled or disabled)
Discriminator: Adjustable from 2- 100 mV at threshold setting of 1.00
RS-232: 9-pin connector for printer or software interface
Detector Cable Connector: Series "C"
Power: 85-250 VAC 50-60 Hz single phase (< 100 mA) or four (4) D-cell batteries
Battery life: Typically 120 hours with alkaline batteries (battery check on meter)
Housing: Aluminum, beige polyurethane enamel paint
Dimensions: 8.5" h x 5" w x 9.3" depth (21.6 x 12.7 x 23.5 cm)
Weight: 6.91b (3.1 kg) without batteries
187-243 ***Well Counter:***
Dimensions: 8" w x 8" depth x 11.75" h (20 x 20 x 30 cm)
Well: .625" dia x 1.4" h (2 x 4 cm)
Lead Shielding: 1" thick (2.5 cm)
Construction: Monoline Weight: 30 **Ib** (14 kg)
051-443 *Low Energy Gamma Scintillation Probe:*
Indicated Use: 1-125 and X-ray survey Energy Response: Energy dependent
Operating Voltage: Typically 500-1200 volts
Scintillator: 1" diameter (2.5 cm), 1 mm thick NaI(Tl) crystal Entry Window: 15 mg/cm2
Window Area: 5 cm2 active and open
Background (10pR/hr): Typically 350 cpm Efficiency (4pi): 19% for 1-125
Sensitivity: 675 *cpm/~R/hr* (1-125)
Recommended Energy Range: 10-60 keV
Tube: 1.5" dia (3.8 cm) magnetically shielded multiplier
Dynode String Resistance: 100 megohm
Cable: 39" l (99 cm), type "C" connectors
Dimensions: 2" dia x 7"1 (5.1 x 17.8 cm)
Weight: 1 lb (0.5 kg)

051-220	Ludlum Model 2200 Portable Scaler Ratemeter	**$1,775.00**
187-243	Well Counter	**$1,840.00**
066-350	Replacement "D" Cell Battery	**ea./$2.50**
006-350	Wipe Test Smears (500)	**$65.00**

To place an order, call 1-800-682-2226.

CAPINTEC, INC.

6 ARROW ROAD
RAMSEY, NEW JERSEY 07446 USA
PHONE: (201) 825-9500
FAX: (201) 825-4829

QUOTATION

No. A99-3296

DATE: September 14, 2004

TO: **Society of Nuclear Medicine**
1850 Samuel Morse Drive
Reston, VA 20190

Attn: Matt Cross, Public Affairs Assistant

DELIVERY: Two to Four Weeks

F.O.B.: Pittsburgh, PA

TERMS: NET 30

We are pleased to submit our quotation for the following:

ITEM	QUAN	DESCRIPTION	PRICE	AMOUNT
5430-2057	1	**CAPRAC WIPE TEST/WELL COUNTER** ***Less Discount of $241.50*** This unit detects levels of contamination lower than 200 dpm for wipes from non-restricted areas, patient rooms, and iodine activities. Reads in nCi (nanocuries), Bq (becquerels), and/or dpm (disintegrations per minute) Energy discrimination	$3,450.00	$3,450.00 **$3,208.50**
5430-0058	1	Optional Epson printer. Contaminated samples above user defined threshold are printed in red.	$412.00	$412.00
5420-2072	1	Optional lead shield increases the shielding around the well from the standard 0.5" to 1.0".	$186.00	$186.00
0975-137R	1	Cs-137 Rod Source (0.5 μCi) ***Less Discount of $9.95***	$199.00	$199.00 **$189.05**
0670-0016	1	Counting Vials (250/pk.)	$44.00	$44.00
5420-0086	1	Absorbent Wipes (500/pk.)	$51.50	$51.50
9282-0009	1	Paper/12 Rolls for Printer	$30.90	$30.90

WARRANTY: 12 Months
Please Return Warranty Registration Card

Quotation is valid for: 60 Days

PER:

Addendum A
HISTORY OF PET CODES

Clinical Condition	Effective Date	Coverage	G-Code	History	No. of Changes	No. of G-Codes Effective 10.04 by Clinical Condition
Solitary Pulmonary Nodules (SPNs)	January 1, 1998	Characterization	G0125	1) Still used for SPN – full & partial ring scanners 2) Replaced by G0234 – gamma cameras – 01.02	1	2
Lung Cancer (Non Small Cell)	January 1, 1998	Initial staging	G0126	1) Replaced by G0211 07.01	1	0
Lung Cancer (Non Small Cell)	July 1, 2001	Diagnosis, staging and restaging	G0210, 0211, 0212	New 07.01 Still effective 10.04		3
Esophageal Cancer	July 1, 2001	Diagnosis, staging and restaging	G0226, 0227, 0228	New 07.01 Still effective 10.04		3
Colorectal Cancer	July 1, 1999	Determining location of tumors if rising CEA level suggests recurrence	G0163	1) Replaced by G0215 07.01 2) Replaced by G0231 – gamma cameras – 01.02	2	1
Colorectal Cancer	July 1, 2001	Diagnosis, staging and restaging	G-213, 0214, 0215	New 07.01 Still effective 10.04		3
Lymphoma	July 1, 1999	Staging and restaging only when used as an alternative to Gallium scan	G0164	1) Replaced by G0222 07.01 2) Replaced by G0232 – gamma cameras – 01.02	2	1
Lymphoma	July 1, 2001	Diagnosis, staging and restaging	G0220, 0221, 0222	New 07.01 Still effective 10.04		3

Clinical Condition	Effective Date	Coverage	G-Code	History	No. of Changes	No. of G-Codes Effective 10.04 by Clinical Condition
Melanoma	July 1, 1999	Evaluating recurrence prior to surgery as an alternative to a Gallium scan	G0165	1) Replaced by G0218 07.01 2) Replaced by G0233 – gamma cameras – 01.02 G0219 (a non covered code) – for non-covered indications	2	1
Melanoma	July 1, 2001	Diagnosis, staging and restaging; Non-covered for evaluating regional nodes	G0216, 0217, 0218	New 07.01 Still effective 10.04		4* 1 non-covered code
Breast Cancer	October 1, 2002	Staging patients with distant metastasis or restaging patients with locoregional recurrence or metastasis; monitoring tumor response to treatment for women with locally advanced and metastatic breast cancer when a change in therapy is anticipated.	G0253, 0254	New 10.02 Still effective 10.04 G0252 (a non-covered code) - initial staging axillary lymph nodes		3* 1 non-covered code
Head and Neck Cancers (excluding CNS and thyroid)	July 1, 2001	Diagnosis, staging and restaging	G0223, 0224, 0225	New 07.01 Still effective 10.04		3

Clinical Condition	Effective Date	Coverage	G-Code	History	No. of Changes	No. of G-Codes Effective 10.04 by Clinical Condition
Thyroid Cancer	October 1, 2003	Restaging of recurrent or residual thyroid cancers of follicular cell origin that have been previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and negative I-131 whole body scan performed	G0296	New 10.03 Still effective 10.04		1
Myocardial Viability	July 1, 2001 to September 30, 2002	Covered only following inconclusive SPECT	G0230	New 07.01 Is this code still active?		1* Is G0230 still active?
Myocardial Viability	October 1, 2002	Primary or initial diagnosis, or following an inconclusive SPECT prior to revascularization. SPECT may not be used following an inconclusive PET scan	**78459**	New 10.02 Still effective 10.04 **THIS IS THE ONLY CPT CODE USED BY CMS FOR FDG PET.**		1
Perfusion of the heart using Rubidium 82 tracer	March 14, 1995	Covered for noninvasive imaging of the perfusion of the heart (strict criteria – prior procedures required – single and/or multiple studies)	G0030 – 0047	New 03.95 Still effective 10.04		18

Clinical Condition	Effective Date	Coverage	G-Code	History	No. of Changes	No. of G-Codes Effective 10.04 by Clinical Condition
Perfusion of the heart using ammonia N-13 tracer	October 1, 2003	Covered for noninvasive imaging of the perfusion of the heart (strict criteria – prior procedures required – single and/or multiple studies)	G0030 - 0047	New 10.03 Still effective 10.04		18* Same codes used for Rubidium cardiac studies
Refractory Seizures	July 1, 2001	Covered for pre-surgical evaluation only	G0229	New 07.01 Still effective 10.04		1
Alzheimer's disease	September 15, 2004	Covered for diagnosis of early dementia in elderly patients for whom the differential diagnosis includes neurodegenerative diseases	G0336	New 09.15.04		1
Summary Clinical Condition	**Effective Date**	**Coverage**			**Total No. of Changes**	**Total No. of G-Codes Effective 10.04**
9 oncologic indications	1998-2003	Varied by disease category			8 changes	28 oncologic HCPCS codes
3 cardiac indications	1995-2003	Varied by clinical condition				18 perfusion cardiac HCPCS codes 1 HCPCS viability code **1 CPT viability code**
2 Brain Alzheimer's* * Clinical trial support	2001-2004	Refractory seizures AD vs FTD Clinical trial				2 brain HCPCS codes

Summary of PET codes:

There are **28 oncology** specific HCPCS codes. There have been 8 changes/updates to these codes since 1998. There are specific coverage requirements for breast cancer, SPN, and thyroid cancer (code specific) and more general coverage definitions for diagnosis, staging & restaging for lung cancer, esophageal cancer, colorectal cancer, H & N cancer, melanoma and lymphoma.

There are **2 brain** specific HCPCS codes. There have been no updates or changes to the original codes. These codes have specific coverage requirements for refractory seizures and diagnosis of Alzheimer's disease.

There are **18 cardiac perfusion** HCPCS codes for coverage specific to Rubidium – 82 and N – 13 Ammonia studies. These codes were developed in 1995 and describe the nuclear medicine, echocardiogram, stress/rest ECG, or angiogram procedure that was performed prior to the PET scan and certain codes designate whether the PET scan is a single rest or stress or multiple rest or stress study.

There are **2 cardiac viability** codes, 1 is a HCPCS code and **1 is a CPT code**. There are specific coverage requirements for these codes – the HCPCS code is valid for PET procedures performed following an inconclusive SPECT and the CPT code is valid for PET procedures performed for initial diagnosis or following an inconclusive SPECT. After re-reviewing the May 2002 Transmittal 156, I believe the G0230 code should be discontinued based on the description of the newest covered clinical guidelines. Please note that G0230 resides in the WB APC with the oncologic and brain codes and the CPT code – 78459 – describing the latest coverage effective 10.02 resides in the cardiac APC with the perfusion codes. I have forwarded Transmittal 156 for your review.

Addendum B Positron Emission Tomography (PET) Sample Medicare clinical conditions & codes FI/Carrier _____

Clinical Condition	Billing Codes	ICD 9 CM CODES
Lung Cancer (SPN)	**G0125** PET imaging regional or whole body; single pulmonary nodule	**518.89** – Other disease of lung, not elsewhere classified (Broncholithiasis; Lung disease NOS; Calcification of lung; Pulmolithiasis) **786.6 –** Lung mass unspecified
Lung Cancer (non-small cell)	**G0210 Diagnosis**; lung cancer, non-small cell **G0211 Initial staging**; lung cancer, non-small cell **G0212 Restaging**; lung cancer, non-small cell	**PET routinely used for diagnosis NSCLC –** **no ICD-9 code limitations** **162.0 – 162.9** Malignant neoplasm (non-small cell) of trachea, bronchus, & lung
Esophageal Cancer	**G0226 Diagnosis;** esophageal cancer **G0227 Initial staging**; esophageal cancer **G0228 Restaging**; esophageal cancer	**150.0 – 150.9** Malignant neoplasm of esophagus
Colorectal Cancer	**G0213 Diagnosis**; colorectal cancer **G0214 Initial staging**; colorectal cancer **G0215 Restaging**; colorectal cancer	**153.0 – 154.1** Malignant neoplasm of colon, rectum, rectosigmoid junction and anus **154.8** Other
Lymphoma	**G0220 Diagnosis**; lymphoma **G0221 Initial staging**; lymphoma **G0222 Restaging**; lymphoma	**200.00 – 200.08** Reticulosarcoma **200.10 – 200.18** Lymphosarcoma **200.20 – 200.28** Burkitt's tumor or lymphoma **200.80 – 200.88** Other named variants **201.00 – 201.08** Hodgkin's paragranuloma **201.10 – 201.18** Hodgkin's granuloma **201.20 – 201.28** Hodgkin's sarcoma **201.40 – 201.48** Lymphocytic-histiocytic predominance **201.50 – 201.58** Nodular sclerosis **201.60 – 201.68** Mixed cellularity **201.70 – 201.78** Lymphocytic depletion **201.90 – 201.98** Hodgkin's disease, unspecified **202.00 – 202.08** Nodular lymphoma **202.80 – 202.88** Other lymphomas
Thyroid Cancer	**G0296 Restaging;** Recurrent or residual thyroid cancer (follicular cell origin; serum thyroglobulin > 10 ng/ml; neg I-131 scan)	**193 –** Malignant neoplasm of thyroid gland

Clinical Condition	Billing Codes	ICD 9 CM CODES
Melanoma	**G0216 Diagnosis**; melanoma **G0217 Initial staging**; melanoma **G0218 Restaging**; melanoma **G0219** melanoma for non-covered indications	**172.0 – 172.9** Malignant neoplasm of skin
Head and Neck Cancers (excluding CNS and thyroid)	**G0223 Diagnosis**; head and neck cancer **G0224 Initial staging**; head and neck cancer **G0225 Restaging**; head and neck cancer	**PET routinely used for diagnosis H & N ca** **no ICD-9 code limitations** **140.0 – 140.1** Malignant neoplasm of lip **140.3 – 140.6** **140.8 – 140.9** **141.0 – 141.6** Malignant neoplasm of tongue **141.8 – 141.9** **142.0 – 142.2** Malignant neoplasm of major salivary glands **142.8 – 142.9** **143.0 – 143.1** Malignant neoplasm of gum **143.8 – 143.9** **144.0 – 144.1** Malignant neoplasm of floor of mouth **144.8 – 144.9** **145.0 – 145.6** Malignant neoplasm of other and unspecified part of mouth **145.8 – 145.9** **146.0 – 146.9** Malignant neoplasm of oropharynx **147.0 – 147.3** Malignant neoplasm of nasopharynx **147.8 – 147.9** **148.0 – 148.9** Malignant neoplasm of hypopharynx **148.8 – 148.9** **149.0 – 149.1** Malignant neoplasm of other and ill-defined sites within the lip, oral cavity and pharynx **149.8 – 149.9** **160.0 – 160.5** Malignant neoplasm of nasal cavities, middle ear and accessory sinuses **160.8 – 160.9** **161.0 – 161.3** Malignant neoplasm of larynx **161.8 – 161.9**
Breast Cancer	**G0253 Staging** distant metastasis; **Restaging** locoregional recurrence or metastasis **G0254 Evaluation** of response to treatment **G0252** Initial diagnosis of breast cancer and/or surgical planning for breast cancer – not covered by Medicare	**174.0-174.9** Malignant neoplasm of female breast, nipple and areola, central portion, upper- lower-inner quadrant, upper-lower outer quadrant, axillary tail, other specified sites of female breast, breast (female) unspecified

Clinical Condition	Billing Codes	ICD 9 CM CODES
Myocardial Viability	**G0230** Metabolic assessment for myocardial viability following inconclusive SPECT	**410.00 – 410.02** Acute myocardial infarction **410.10 – 410.12** **410.20 – 410.22** **410.30 – 410.32** **410.40 – 410.42** **410.50 – 410.52** **410.60 – 410.62** **410.70 – 410.72** **410.80 – 410.82** **410.90 – 410.92** **411.0 – 411.1** Other acute and subacute forms of ischemic heart disease **411.81** Acute coronary occlusion without myocardial infarction **411.89** Other **413.0 – 413.1** Angina pectoris **413.9** **414.00 – 414.03** Coronary atherosclerosis **414.10** Aneurysm of heart (wall) **414.8** Other specified form of chronic ischemic heart disease
Refractory Seizures	**G0229** Metabolic brain imaging for pre-surgical evaluation of refractory seizures	**345.01** Generalized non-convulsive epilepsy with intractable epilepsy **345.11** Generalized convulsive epilepsy with intractable epilepsy **345.2** Petit mal status **345.3** Grand mal status **345.41** Partial epilepsy, with impairment of consciousness with intractable epilepsy **345.51** Partial epilepsy, without mention of impairment of consciousness with intractable epilepsy **345.61** Infantile spasms with intractable epilepsy **345.71** Epilepsia partialis continua with intractable epilepsy **345.81** Other forms of epilepsy with intractable epilepsy **345.91** Epilepsy, unspecified with intractable epilepsy

Submitter : Ms. Cheryl McKay **Date & Time:** 09/24/2004 01:09:26

Organization : The Refined Touch

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please do not pass this policy whereby a physician can refer "incident to" sevices to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

Submitter : Ms. Margaret Sligh **Date & Time:** 09/24/2004 01:09:55

Organization : Ms. Margaret Sligh

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer
"incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision

CMS-1429-P-3616

Submitter : Mr. nicholas forsythe **Date & Time:** 09/24/2004 01:09:04

Organization : Indiana University

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am an Athletic training student at Indiana University and will be graduating in December. The proposed revisions concerning the profession of athletic training is threatening my career as an athletic trainer. We provide immediate care and rehabilitation of injuries as well as take care of chronic overuse problems. State of the art equipment has been a major part of our learning environment which will continue to better the athletes we deal with as well as the general public. Athletic trainers are definitely an added benefit to the medical profession and will continue to work along with all other medical branches in order to benefit anyone who may need our help.

Submitter : Mr. Jason McCamey **Date & Time:** 09/24/2004 01:09:46

Organization : National Athletic Trainers Association

Category : Physician Assistant

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

'Therapy-Incident To'

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

CMS-1429-P-3617-Attach-1.doc

Jason Jerry McCamey
627 W. Dennis Dr.
Clovis, CA 93612

9/10/04

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

This letter is in response to the recent proposal that would limit providers of "incident to" services in physician offices and clinics. I am extremely concerned that, if approved, this bill will eliminate the ability of competent health care professionals to provide these services. Consequently, limiting or decreasing the availability for these Medicare patients to receive the quality care they are seeking. This will have a profound effect on the cost of these services to the patient and place an unjustifiable burden on the current health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be

forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes

from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Jason Jerry McCamey, MS, ATC

CMS-1429-P-3618

Submitter : Ms. Concetta Di Piazza **Date & Time:** 09/24/2004 01:09:33

Organization : In Touch Therapy

Category : Other Health Care Provider

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I oppose Medicare's proposed policy to eliminate any provider except PT's from providing medical professional's services to patients. As a health professional and client, I find that alternative methods such as Massage Therapy provide equal and sometime better relief than other methods. A few of my clients have come to my office after having no success with prescribed drugs and Physical Therapy.
For those who are for this policy; you should try Massage Therapy as an alternative therapy. It does work.

Submitter : melanie stillion **Date & Time:** 09/24/2004 01:09:47

Organization : AOBTA

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Under the current proposal, medicare, patients, and qualified therapists all lose. PLease do NOT pass this policy whereby a physician can only refer "incident to" services to physical therpists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

Submitter : **Date & Time:** 09/24/2004 01:09:40

Organization :

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I would never visit a podiatrist for my toothache. It is the quality of care I seek from a professional trained in my particular ailment I will require. The most skilled and educated professional will administer optimal care, safety and assistance in my maintaining a healthy life.

CMS-1429-P-3621

Submitter : Dr. Terry Grindstaff **Date & Time:** 09/24/2004 01:09:27

Organization : University of Virginia

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

?Please see attached file?

A financial limitation on the provision of therapy services (referred to as the therapy cap) is scheduled to become effective January 1, 2006. Under the current Medicare policy, a patient could exceed his/her cap on therapy without ever receiving services from a physical therapist. This will negatively impact patient?s outcomes.

CMS-1429-P-3621-Attach-1.doc

Terry L. Grindstaff
706 Altavista Ave
Charlottesville, VA 22902

September 23, 2004

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To (Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005)

Dear Dr. McClellan:

My name is Terry Grindstaff and I am a physical therapist and a certified athletic trainer. I am writing to express my concern over the recent proposal which would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important rehabilitation services. In turn, it would reduce the quality of health care for our Medicare patients, ultimately increase the costs associated with this service, and place an undue burden on the health care system.

As a physical therapist and a certified athletic trainer I can attest to the qualifications of certified athletic trainers to provide orthopedic care under the supervision of a physician. The American Medical Association recognizes athletic training as an allied healthcare profession. I am offended by the fact that the American Physical Therapy Association would consider a certified athletic trainer unqualified to provide services under the supervision of a physician.

Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor's or master's degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology, biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology.

Seventy (70) percent of all athletic trainers have a master's degree or higher. This great majority of practitioners who hold advanced degrees are comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs

are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during fitness activities. In addition, dozens of athletic trainers accompanied the U.S. Olympic Team to Athens, Greece this summer to provide services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of their injury is outrageous and unjustified.

To only allow physical therapists, PT assistants, occupational therapists, OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

Our country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, cost the patient in time and travel expenses. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Terry L. Grindstaff, PT, ATC
Physical Therapist/Certified Athletic Trainer

Submitter : Mr. Lazaro Cardenas **Date & Time:** 09/24/2004 01:09:00

Organization : Notre Dame High School, Belmont

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

"Please See Attached File"

CMS-1429-P-3622-Attach-1.doc

Via Electronic Mail -- http://www.cms.hhs.gov/regulations/ecomments

Laz Cardenas Jr., MS, ATC, CSCS
Head Athletic Trainer, Notre Dame High School, Belmont
Shifting Sands Medical Association
1540 Ralston Avenue
Belmont, CA 94002-1908

September 15, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

I am one of those providers you would limit if this proposal is put into place. I am an Athletic Trainer at a prominent secondary school in Northern California. I am entrusted by the faculty and parents to keep their children/student-athletes as healthy as possible. This includes: prevention of injuries and illnesses; assessment and evaluation; rehabilitation; and administration. The only way I am able to do my job is because of the extensive athletic training program I completed and by passing the national board exam for athletic trainers. I completed over 3,000 clinical hours in my training. I am not going to say that I can handle anything that a physician might throw at me, but if a person incurs an injury that was brought about by movement, as an athletic trainer I am very well equipped to handle the situation. I treat and rehabilitate over 300 injuries a year. In most case include ankle, knee, back, and shoulder injuries. I also rehabilitate post operative injuries. In the majority of the cases, while working with the student athlete's physician, I am able to get the student-athlete back to activities of daily living and return to play status in a reasonable time, with hardly any reoccurrence of the injury. In our training we are taught that each injury is unique and should be handled accordingly based on their age, gender, and fitness level. In my opinion, athletic trainers are a very useful resource for physicians, especially orthopaedic physicians.

During the decision-making process, please consider the following:

- "Incident to" has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY "incident to" service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. ***It is imperative that physicians continue to make decisions in the best interests of the patients.***

- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

- Athletic trainers are highly educated. ALL certified or licensed athletic trainers ***must have a bachelor's or master's degree*** from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master's degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

- To allow *only* physical therapists, occupational therapists, and speech and language pathologists to provide "incident to" outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide "incident to" outpatient therapy in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. ***In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.***

- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes

to **prevent, assess, treat and rehabilitate** injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Laz Cardenas Jr., MS, ATC, CSCS

CMS-1429-P-3623

Submitter : Miss. Nadiya Cyril **Date & Time:** 09/24/2004 01:09:42

Organization : Miss. Nadiya Cyril

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I agree that the Association strongly opposes the use of unqualified personnel to furnish physical therapy services. I am a Physical Therapy Assistant student and although I have no personal experience on this matter, I do feel that it has a negative impact of using unqualified personnel to furnish physical therapy services. They should be billed under their own therapy.

Submitter : Mrs. Dayna McCall **Date & Time:** 09/24/2004 01:09:54

Organization : UMDNJ

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

September 23, 2004

The Center for Medicare and Medicaid Services

Dear Sir or Madam:

Would you want your barber performing surgery on you or a loved one? Back in the 1800?s it was common place for a local barber to practice medicine. It is now the year 2004, and unqualified personnel are still providing medical services! The proposed 2005 Medicare physician fee schedule rule can make a difference in the evolution of healthcare.

Physical therapy is a profession that involves a great deal of knowledge and specialized skill. I am currently enrolled in the Doctor of Physical Therapy Program at The University of Medicine and Dentistry of New Jersey. In order to become qualified to practice physical therapy I must complete seven years of schooling, four clinical affiliations, and pass a state licensing examination. It is imperative that I prove my level of competence so that the public will receive safe and effective treatment.

No one other than a licensed physical therapist encompasses the expertise needed to perform physical therapy. The physician fee schedule rule can maintain healthcare standards, protect patients, and ensure that credible services be administered to patients. Therefore I strongly support the proposed personnel standards for physical therapy services provided ?incident to? physician services.

Sincerely,

Dayna McCall
Student Physical Therapist
UMDNJ

CMS-1429-P-3624-Attach-1.doc

February 4, 2005

The Center for Medicare and Medicaid Services

Dear Sir or Madam:

Would you want your barber performing surgery on you or a loved one? Back in the 1800's it was common place for a local barber to practice medicine. It is now the year 2004, and unqualified personnel are still providing medical services! The proposed 2005 Medicare physician fee schedule rule can make a difference in the evolution of healthcare.

Physical therapy is a profession that involves a great deal of knowledge and specialized skill. I am currently enrolled in the Doctor of Physical Therapy Program at The University of Medicine and Dentistry of New Jersey. In order to become qualified to practice physical therapy I must complete seven years of schooling, four clinical affiliations, and pass a state licensing examination. It is imperative that I prove my level of competence so that the public will receive safe and effective treatment.

No one other than a licensed physical therapist encompasses the expertise needed to perform physical therapy. The physician fee schedule rule can maintain healthcare standards, protect patients, and ensure that credible services be administered to patients. Therefore I strongly support the proposed personnel standards for physical therapy services provided "incident to" physician services.

Sincerely,

Dayna McCall

Student Physical Therapist
UMDNJ

CMS-1429-P-3625

Submitter : Ms. Anna Owsley **Date & Time:** 09/24/2004 01:09:47

Organization : Ms. Anna Owsley

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

PLEASE CONSIDER THE FOLLOWING LETTER REGARDING CMS-1429-P

CMS-1429-P-3625-Attach-1.doc

Anna Owsley, MS, LAT, ATC
St. Vincent Sports Medicine
8227 Northwest Blvd, #160
Indianapolis, IN 46278

September 23rd, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy- Incident to

Dear Sir/Madam

I am writing regarding the recent proposal by the Centers for Medicare & Medicaid Services that would limit providers of "incident to" services in physician offices and clinics. This proposal, if adopted would eliminate the ability of healthcare professional to provide services that they are more than qualified to render. Furthermore, it would decrease the quality and timeliness of health care that Medicare patients receive.

Please consider the following during your decision making process:

1. A physician has the right to delegate the care of his/her patients to trained healthcare professionals (including certified athletic trainers) whom he/she deems qualified. "Incident to" has been utilized by physicians in this manner since the inception of the Medicare program in 1965. The physician accepts the legal responsibility for the individual under their supervision. It is the individual physician's responsibility to determine who is qualified to provide services to their patients. **It is imperative the physicians continue to be able to make decisions in the best interest of their patient.**
2. Patients have the right to seek accessible and comprehensive health care. The change to "incident to" services reimbursement could force a patient to see the physician at one location and seek therapy treatments elsewhere. This would be especially inconvenient for patients who were only to receive a home exercise program.
3. Athletic trainers are highly educated individuals. **All** certified athletic trainers have either a bachelor's or master's degree from an accredited university. Academic programs are accredited by CAAHEP via the Joint Review Committee on educational programs in Athletic Training (JRC-AT). Additionally 70% of all athletic trainers have their masters degree or higher. The suggestion that an individual with the qualifications can not provide services under the direction of a physician is ludicrous.

4. If physical therapist, occupational therapists, and speech and language pathologists are the only healthcare professionals allowed to provide “incident to” outpatient therapy services than this would give these professions a monopoly on Medicare reimbursement for therapy services.
5. **There is no evidence that has been introduced that this is a problem that needs fixing.** However, this proposed change seems to have been proposed to appease the interests of a single professional group who appear to be trying to establish themselves as the sole provider of therapy services. CMS does not have the statutory authority to restrict who can and can not provide services “incident to” a physician office visit.
6. As an athletic trainer who has worked with professional, Olympic, collegiate, high school & junior high athletes as well as numerous “weekend warriors” I take extreme offense at the notion that I am not qualified to work with someone who injures themselves while walking for exercise. Apparently athletic trainers are qualified to provide care for our country’s best athletes, but according to the CMS proposal are not qualified to treat Medicare beneficiaries.

In summary, I urge that you consider the facts not justify this blatant attempt by another professional organization to obtain exclusive rights to Medicare reimbursement for therapy services.

Sincerely,

Anna Owsley, MS, LAT, ATC

CMS-1429-P-3626

Submitter : Miss. Nadiya Cyril **Date & Time:** 09/24/2004 01:09:55

Organization : Miss. Nadiya Cyril

Category : Individual

Issue Areas/Comments

Issues 10-19

THERAPY ASSISTANTS IN PRIVATE PRACTICE

No in room supervision of PTA's, rather in clinic

Submitter : Mr. Richard A Nevill, Jr. **Date & Time:** 09/24/2004 01:09:03

Organization : Mr. Richard A Nevill, Jr.

Category : Physician Assistant

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I do not agree that only physical therapists should be the only health care professionals allowed to provide medically related care to physician's patients. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

Submitter : Mrs. Melanie Bauer **Date & Time:** 09/24/2004 01:09:29

Organization : Orthopaedic Center of Southern Illinois

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

ASSIGNMENT

I am a Certified Athletic Trainer and I worked in an orthopaedic clinic providing care for many medicare and medicaid patients. I am very upset about this new revision on not allowing athletic trainers to provide care to this people population. Certified athletic trainers are required to attend a 4 year undergraduate program to become skilled in providing care and rehabilitation to injuries, while only most Physical THerapy assistants have 2 years of schooling.
We (ATC)focus on sport but we also focus on other orthopaedic injuries that occur outside of sport. Our required curricula include classes such as Advanced rehabilitation techniques, modalities, kinesiology, biomechanics, emergency care, and more involved classes. ALong with class room work we are required througout our college career to work in many different clinical settings to learn and acquire skills not only in the sport setting but also in industry, clinical and injury prevention fields.
While having most of my work experience in a clinical setting I feel that I have as much knowledge as a physical therapist assistant and I could also add more skill in my rehab techniques to those patients who were still physically active and I am able to provide help for those patients who may not be. Please do not take away our priviledges for working on medicare and medicaid patients. These patients need our help to get better and live healthier and happier lives.

CARE PLAN OVERSIGHT

I am a Certified Athletic Trainer and I worked in an orthopaedic clinic providing care for many medicare and medicaid patients. I am very upset about this new revision on not allowing athletic trainers to provide care to this people population. Certified athletic trainers are required to attend a 4 year undergraduate program to become skilled in providing care and rehabilitation to injuries, while only most Physical THerapy assistants have 2 years of schooling.
We (ATC)focus on sport but we also focus on other orthopaedic injuries that occur outside of sport. Our required curricula include classes such as Advanced rehabilitation techniques, modalities, kinesiology, biomechanics, emergency care, and more involved classes. ALong with class room work we are required througout our college career to work in many different clinical settings to learn and acquire skills not only in the sport setting but also in industry, clinical and injury prevention fields.
While having most of my work experience in a clinical setting I feel that I have as much knowledge as a physical therapist assistant and I could also add more skill in my rehab techniques to those patients who were still physically active and I am able to provide help for those patients who may not be. Please do not take away our priviledges for working on medicare and medicaid patients. These patients need our help to get better and live healthier and happier lives.

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am a Certified Athletic Trainer and I worked in an orthopaedic clinic providing care for many medicare and medicaid patients. I am very upset about this new revision on not allowing athletic trainers to provide care to this people population. Certified athletic trainers are required to attend a 4 year undergraduate program to become skilled in providing care and rehabilitation to injuries, while only most Physical THerapy assistants have 2 years of schooling.
We (ATC)focus on sport but we also focus on other orthopaedic injuries that occur outside of sport. Our required curricula include classes such as Advanced rehabilitation techniques, modalities, kinesiology, biomechanics, emergency care, and more involved classes. ALong with class room work we are required througout our college career to work in many different clinical settings to learn and acquire skills not only in the sport setting but also in industry, clinical and injury prevention fields.
While having most of my work experience in a clinical setting I feel that I have as much knowledge as a physical therapist assistant and I could also add more skill in my rehab techniques to those patients who were still physically active and I am able to provide help for those patients who may not be. Please do not take away our priviledges for working on medicare and medicaid patients. These patients need our help to get better and live healthier and happier lives.

IMPACT

I am a Certified Athletic Trainer and I worked in an orthopaedic clinic providing care for many medicare and medicaid patients. I am very upset about this new revision on not allowing athletic trainers to provide care to this people population. Certified athletic trainers are required to attend a 4 year undergraduate program to become skilled in providing care and rehabilitation to injuries, while only most Physical THerapy assistants have 2 years of schooling.
We (ATC)focus on sport but we also focus on other orthopaedic injuries that occur outside of sport. Our required curricula include classes such as Advanced rehabilitation techniques, modalities, kinesiology, biomechanics, emergency care, and more involved classes. ALong with class room work we are required througout our college career to work in many different clinical settings to learn and acquire skills not only in the sport setting but also in industry, clinical and injury prevention fields.
While having most of my work experience in a clinical setting I feel that I have as much knowledge as a physical therapist assistant and I could also add more skill in my rehab techniques to those patients who were still physically active and I am able to provide help for those patients who may not be. Please do not take away our priviledges for working on medicare and medicaid patients. These patients need our help to get better and live healthier and happier lives.

LOW OSMOLAR CONTRAST MEDIA

I am a Certified Athletic Trainer and I worked in an orthopaedic clinic providing care for many medicare and medicaid patients. I am very upset about this new revision on not allowing athletic trainers to provide care to this people population. Certified athletic trainers are required to attend a 4 year undergraduate program to become skilled in providing care and rehabilitation to injuries, while only most Physical THerapy assistants have 2 years of schooling.
We (ATC)focus on sport but we also focus on other orthopaedic injuries that occur outside of sport. Our required curricula include classes such as Advanced rehabilitation techniques, modalities, kinesiology, biomechanics, emergency care, and more involved classes. ALong with class room work we are required througout our college career to work in many different clinical settings to learn and acquire skills not only in the sport setting but also in industry, clinical and injury prevention fields.
While having most of my work experience in a clinical setting I feel that I have as much knowledge as a physical therapist assistant and I could also add more skill in my rehab techniques to those patients who were still physically active and I am able to provide help for those patients who may not be. Please do not take away our priviledges for working on medicare and medicaid patients. These patients need our help to get better and live healthier and happier lives.

MANAGING PATIENTS ON DIALYSIS

I am a Certified Athletic Trainer and I worked in an orthopaedic clinic providing care for many medicare and medicaid patients. I am very upset about this new revision on not allowing athletic trainers to provide care to this people population. Certified athletic trainers are required to attend a 4 year undergraduate program to become skilled in providing care and rehabilitation to injuries, while only most Physical THerapy assistants have 2 years of schooling.
We (ATC)focus on sport but we also focus on other orthopaedic injuries that occur outside of sport. Our required curricula include classes such as Advanced rehabilitation techniques, modalities, kinesiology, biomechanics, emergency care, and more involved classes. ALong with class room work we are required througout our college career to work in many different clinical settings to learn and acquire skills not only in the sport setting but also in industry, clinical and injury prevention fields.
While having most of my work experience in a clinical setting I feel that I have as much knowledge as a physical therapist assistant and I could also add more skill in my rehab techniques to those patients who were still physically active and I am able to provide help for those patients who may not be. Please do not take away our priviledges for working on medicare and medicaid patients. These patients need our help to get better and live healthier and happier lives.

TECHNICAL REVISION

I am a Certified Athletic Trainer and I worked in an orthopaedic clinic providing care for many medicare and medicaid patients. I am very upset about this new revision on not allowing athletic trainers to provide care to this people population. Certified athletic trainers are required to attend a 4 year undergraduate program to become skilled in providing care and rehabilitation to injuries, while only most Physical THerapy assistants have 2 years of schooling.
We (ATC)focus on sport but we also focus on other orthopaedic injuries that occur outside of sport. Our required curricula include classes such as Advanced rehabilitation techniques, modalities, kinesiology, biomechanics, emergency care, and more involved classes. ALong with class room work we are required througout our college career to work in many different clinical settings to learn and acquire skills not only in the sport setting but also in industry, clinical and injury prevention fields.
While having most of my work experience in a clinical setting I feel that I have as much knowledge as a physical therapist assistant and I could also add more skill in my rehab techniques to those patients who were still physically active and I am able to provide help for those patients who may not be. Please do not take away our priviledges for working on medicare and medicaid patients. These patients need our help to get better and

live healthier and happier lives.

THERAPY - INCIDENT TO

I am a Certified Athletic Trainer and I worked in an orthopaedic clinic providing care for many medicare and medicaid patients. I am very upset about this new revision on not allowing athletic trainers to provide care to this people population. Certified athletic trainers are required to attend a 4 year undergraduate program to become skilled in providing care and rehabilitation to injuries, while only most Physical THerapy assistants have 2 years of schooling.
We (ATC)focus on sport but we also focus on other orthopaedic injuries that occur outside of sport. Our required curricula include classes such as Advanced rehabilitation techniques, modalities, kinesiology, biomechanics, emergency care, and more involved classes. ALong with class room work we are required througout our college career to work in many different clinical settings to learn and acquire skills not only in the sport setting but also in industry, clinical and injury prevention fields.
While having most of my work experience in a clinical setting I feel that I have as much knowledge as a physical therapist assistant and I could also add more skill in my rehab techniques to those patients who were still physically active and I am able to provide help for those patients who may not be. Please do not take away our priviledges for working on medicare and medicaid patients. These patients need our help to get better and live healthier and happier lives.

THERAPY STANDARDS AND REQUIREMENTS

I am a Certified Athletic Trainer and I worked in an orthopaedic clinic providing care for many medicare and medicaid patients. I am very upset about this new revision on not allowing athletic trainers to provide care to this people population. Certified athletic trainers are required to attend a 4 year undergraduate program to become skilled in providing care and rehabilitation to injuries, while only most Physical THerapy assistants have 2 years of schooling.
We (ATC)focus on sport but we also focus on other orthopaedic injuries that occur outside of sport. Our required curricula include classes such as Advanced rehabilitation techniques, modalities, kinesiology, biomechanics, emergency care, and more involved classes. ALong with class room work we are required througout our college career to work in many different clinical settings to learn and acquire skills not only in the sport setting but also in industry, clinical and injury prevention fields.
While having most of my work experience in a clinical setting I feel that I have as much knowledge as a physical therapist assistant and I could also add more skill in my rehab techniques to those patients who were still physically active and I am able to provide help for those patients who may not be. Please do not take away our priviledges for working on medicare and medicaid patients. These patients need our help to get better and live healthier and happier lives.

THERAPY TECHNICAL REVISIONS

I am a Certified Athletic Trainer and I worked in an orthopaedic clinic providing care for many medicare and medicaid patients. I am very upset about this new revision on not allowing athletic trainers to provide care to this people population. Certified athletic trainers are required to attend a 4 year undergraduate program to become skilled in providing care and rehabilitation to injuries, while only most Physical THerapy assistants have 2 years of schooling.
We (ATC)focus on sport but we also focus on other orthopaedic injuries that occur outside of sport. Our required curricula include classes such as Advanced rehabilitation techniques, modalities, kinesiology, biomechanics, emergency care, and more involved classes. ALong with class room work we are required througout our college career to work in many different clinical settings to learn and acquire skills not only in the sport setting but also in industry, clinical and injury prevention fields.
While having most of my work experience in a clinical setting I feel that I have as much knowledge as a physical therapist assistant and I could also add more skill in my rehab techniques to those patients who were still physically active and I am able to provide help for those patients who may not be. Please do not take away our priviledges for working on medicare and medicaid patients. These patients need our help to get better and live healthier and happier lives.

CMS-1429-P-3629

Submitter : Miss. Donna Wesley **Date & Time:** 09/24/2004 01:09:12

Organization : Mississippi Athletic Trainers' Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See Attached Letter

CMS-1429-P-3629-Attach-1.doc

Mississippi Athletic Trainers' Association, Inc.

September 23, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

On behalf of the over 240 licensed, certified athletic trainers in Mississippi, I am writing to express our concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals, including Certified Athletic Trainers (ATCs) to provide these important services. During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others (including ATCs), under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere. In our predominantly rural state, this would cause a significant inconvenience and additional expense to the patient. Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

- Mississippi, like many states is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. It is insulting to think that ATCs are the health care provider of choice for these elite, multi-million dollar athletes and are not allowed to work with the "weekend warrior" on Medicaid or Medicare.

We request that no changes be made to Medicare or other provisions affecting "Therapy-Incident To" services reimbursement from CMS.

Sincerely,

Donna E. Wesley, ATC/LAT, M.S.

Mississippi Athletic Trainers' Association

President

414 Oak Road

Fulton, MS

Submitter : Mrs. Holly Gunyan **Date & Time:** 09/24/2004 01:09:33

Organization : Mrs. Holly Gunyan

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file.

CMS-1429-P-3630-Attach-1.txt

Attachment #3630

Holly N. Gunyan
101 Melville Loop #10
Chapel Hill, NC 27514

September 23, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

• "Incident to" has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

• There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY "incident to" service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

• In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the

patient.

• This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

• Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

• Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.

• Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have a bachelor's or master's degree from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master's degree or higher. This great majority of practitioners who hold advanced degrees are comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

• To allow only physical therapists, occupational therapists, and speech and language pathologists to provide "incident to" outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide "incident to" outpatient therapy in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

• CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

• CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this action could be construed as an

unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.

• Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

• Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

• These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Holly N. Gunyan
Certified Athletic Trainer

Submitter : David Hennig **Date & Time:** 09/24/2004 01:09:10

Organization : Florida State Massage Therapy Association

Category : Other Health Care Provider

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

As a licensed massage therapist I feel all qualified
health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.
The language I have reviewed could be interpteted to interfere here.

CMS-1429-P-3632

Submitter : Miss. Judith Grandinetti **Date & Time:** 09/24/2004 03:09:23

Organization : PTA Program at NOVA

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

My name is Judy and I am currently enrolled in a PTA program, in Northern Virginia. I have been working at HEALTHSOUTH an out patient PT office for over three years. I feel that it is unfair, and not in the patients best interest a patient to receive Physical Therapy by someone who is not specifically educated in this area. I strongly agree with the CMS's proposed requirement that physical therapists working in physicians offices be graduates of accredited professional physical therapist programs. Its very important that the person treating a patient for P.T. has a license which proves that they have successfully passed the state board. I feel that physical therapists and physical therapist assistants under the supervision of physical therapist are the only practitioners who have the education and training to furnish physical therapy services. In my work as a tech, I know that it is very important to have your patient do their exercise appropriately. You must have your patients in particular positions using the correct muscle in order for the patient to improve. Unqualified personnel should NOT be providing physical therapy services.

Submitter : Margaret Brownlie **Date & Time:** 09/24/2004 01:09:55

Organization : Associated Bodywork

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am adamantly opposed this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health professionals should be allowed to provide services to patients with a physicians perscriptionn or under supervision. Please do not further limit the choices of patients.

Submitter : Miss. Tereza Pochman **Date & Time:** 09/24/2004 01:09:10

Organization : Regis University

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

Tereza Pochman
Doctor of Physical Therapy Student
1146 Opal St. #103
Broomfield, CO 80020

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

I am a third-year Doctor of Physical Therapy (DPT) student at Regis University in Denver, CO and will be graduating in May 2005. Majority of my clinical experience has been in outpatient private practice; however I have also spent time in skilled nursing facilities and adult rehabilitation. I have been actively involved in our professional organization for the past two-years at both the state and national level.

I wish to comment on August 5th proposed rule on ?Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005.? I strongly support the proposal made by CMS that the qualifications of individuals providing physical therapy ?therapy-incident to? a physician should meet qualifications for physical therapy in 42 CFR ? 484.4, with the exception of licensure. As a Doctor of Physical Therapy student we have been expected to be evidence based practitioners and to utilize research to enhance the care we provide to our patients. Our education also provides us with a comprehensive understanding of neuromotor and musculoskeletal function and therefore we are the only appropriate practitioners adequately educated and trained to provide quality therapy services. As of January 2002, a post-baccalaureate degree is the minimum educational requirement to become a physical therapist and by 2005 majority of the programs will offer the Doctor of Physical Therapy. It is insulting and disheartening for me to think that personnel with less education and qualifications than I would be able to provided the therapy services that I have spent years training for.

Having unqualified personnel perform therapy services is harmful to patients because they do not have the ability differentially diagnose complex clinical cases. Our curriculum requires us to be able to recognize when the problem is outside of our scope and make referrals as warranted. I believe in order to guarantee that no patient is harmed from services provided by unqualified personnel it is the duty of CMS to require that physical therapy services be only provided by graduates of accredited professional physical therapist education programs.

In conclusion, I would like to thank you for your time and appreciate your consideration of my concerns on this issue.

Sincerely,

Tereza Pochman

Attachment #3634

Tereza Pochman
Doctor of Physical Therapy Student
1146 Opal St. #103
Broomfield, CO 80020

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

I am a third-year Doctor of Physical Therapy (DPT) student at Regis University in Denver, CO and will be graduating in May 2005. Majority of my clinical experience has been in outpatient private practice; however I have also spent time in skilled nursing facilities and adult rehabilitation. I have been actively involved in our professional organization for the past two-years at both the state and national level.

I wish to comment on August 5th proposed rule on "Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005." I strongly support the proposal made by CMS that the qualifications of individuals providing physical therapy "therapy-incident to" a physician should meet qualifications for physical therapy in 42 CFR § 484.4, with the exception of licensure. As a Doctor of Physical Therapy student we have been expected to be evidence based practitioners and to utilize research to enhance the care we provide to our patients. Our education also provides us with a comprehensive understanding of neuromotor and musculoskeletal function and therefore we are the only appropriate practitioners adequately educated and trained to provide quality therapy services. As of January 2002, a post-baccalaureate degree is the minimum educational requirement to become a physical therapist and by 2005 majority of the programs will offer the Doctor of Physical Therapy. It is insulting and disheartening for me to think that personnel with less education and qualifications than I would be able to provided the therapy services that I have spent years training for.

Having unqualified personnel perform therapy services is harmful to patients because they do not have the ability differentially diagnose complex clinical cases. Our curriculum requires us to be able to recognize when the problem is outside of our scope and make referrals as warranted. I believe in order to guarantee that no patient is harmed from services provided by unqualified personnel it is the duty of CMS to require that physical therapy services be only provided by graduates of accredited professional physical therapist education programs.

In conclusion, I would like to thank you for your time and appreciate your consideration of my concerns on this issue.

Sincerely,

Tereza Pochman

Attachment # 3634 (2 of 2)
Courtney Rosenbaum
P.O. Box 72
Campbell Hall, NY 10916

September 23, 2004
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012
Re: Therapy – Incident To
Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the

medical expenditures of Medicare.

Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.

To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.

Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists. Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Courtney Rosenbaum
P.O. Box 72
Campbell Hall, NY 10916

Submitter : Mr. Bart Welte **Date & Time:** 09/24/2004 01:09:51

Organization : Blanchard Valley Health Association

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy-Incident to

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. During the decision-making process, please consider the following:
1) "Incident to" has, since the inception of the medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has a right to delegate the care of his or her patients to trained individuals (including ATHLETIC TRAINERS) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician' CHOICE of quality therapy provider is inherent in the type of practice, medical subspecialty and the individual. It is imperitive that physicians continue to make decisions in the best interests of the patients.
2) To allow only physical therapists, occupational therapists, and speech and language pathologists to provide "incident to" outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide "incident to" outpatient therapy in physicians' offices would improperly remove the right to license and regulate the allied health professions deemed qualified, safe, and appropriate to provide health care services.
In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.
Sincerely,
Bart Welte MS,ATC,LAT
Ohio #AT1314

CMS-1429-P-3636

Submitter : **Date & Time:** **09/24/2004 02:09:13**

Organization :

Category : **Physical Therapist**

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I support CMS's proposal in the rule that establishes these standards for personnel providing physical therapy services in physicians' offices. Even though current law prevents the agency from requiring licensure, it would be the most appropriate standard to achieve its objective.

CMS-1429-P-3636-Attach-1.doc

San Marcos, TX 78666

September 22 2004

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Dear Mark B. McClellan, MD, PhD:
I am a second year physical therapy student at Texas State University-SanMarcos, and will graduate in May 2005. The subject of this letter concerns "Therapy-Incident To" and the proposed regulation issued on August 5, 2004

During my affiliation at Detar hospital in Victoria, Texas, I worked with several Medicare patients in acute care. According to Medicare rules and regulations, I was required to treat Medicare patients under the supervision of a licensed physical therapist. These regulations aim to protect the safety of patients by requiring that physical therapy services be provided by qualified personnel.

CMS proposes that qualifications of individuals providing physical therapy services "incident to" a physician should meet personnel qualifications for physical therapy in 42 CFR §484.4, with the exception of licensure. This means that individuals providing physical therapy must be graduates of an accredited professional physical therapist program or must meet certain grandfathering clauses or educational requirements for foreign trained physical therapists. I support CMS's proposal in the rule that establishes these standards for personnel providing physical therapy services in physicians' offices. Even though current law prevents the agency from requiring licensure, it would be the most appropriate standard to achieve its objective.

To become a licensed physical therapist or physical therapy assistant, an individual must complete an accredited professional physical therapy program and pass the state board exam. This ensures that the individual acquires the knowledge and skills to provide adequate patient care. The individual is then subject to rules and regulations enforced by a governing board. Without these rules and regulations, the patient is at an increased risk for insufficient care.

The delivery of so-called "physical therapy services" by unqualified personnel is harmful to the patient. A licensed physical therapist is specially trained in different contraindications and indications for specific services. Without this training, an unqualified provider of physical therapy may provide unnecessary and possibly harmful treatments to patients. This could complicate the original condition and could require the patient to need more care than necessary, increasing the cost of healthcare. It is important to assure that patients are receiving appropriate and necessary care.

Section 1862(a)(20) of the Social Security Act clearly requires that in order for a physician to bill "incident to" for physical therapy services, those services must meet the same requirements for outpatient therapy services in all settings. Thus, the services must be performed by individuals, who are graduates of accredited professional physical therapist education programs.

Thank you for considering my comments.

Sincerely,

Anonymous Physical Therapy Student

CMS-1429-P-3637

Submitter : **Date & Time:** **09/24/2004 02:09:25**

Organization :

Category : **Physician**

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Subject: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

CMS-1429-P-3637-Attach-1.doc

September 23, 2004

Subject: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

Dear Mark B. McClellan, MD, PhD,

Therapy-Incident To: I am a second year student physical therapist at Texas State University-San Marcos. I have been on one full time clinical affiliation, and I wish to comment on the August 5 proposed rule on "Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005." I want to express my strong support for CMS's proposed requirement that physical therapists working in physicians offices be graduates of accredited professional physical therapist programs. In order to become a physical therapist, a strict educational program must be completed, which includes significant training in anatomy and physiology, a broad understanding of the body and its functions, and comprehensive patient care experience. This education and training is particularly important when treating Medicare beneficiaries. The educational requirement culminates in a final examination by which a potential physical therapist proves his or her expertise and qualification to perform physical therapy to the public.

Although physicians receive extensive medical knowledge in medical school, they do not focus on physical therapy education and training as is done in a physical therapy education program. I agree with CMS's stance that individuals providing physical therapy services "incident to" a physician should meet personnel qualifications for physical therapy in 42 CFR §484.4, with the exception of licensure. Personnel performing physical therapy should meet these requirements set by the CMS, otherwise they should not be allowed to perform physical therapy. The requirement of personnel to possess a current physical therapy license would be the best way to enforce and ensure proper standard of physical therapy care is disseminated to patients. This licensure exam is one of the most efficient ways to make sure those who practice physical therapy are actually performing the practice correctly.

Physical therapists are fully accountable for their professional actions by their license. Physical therapists and physical therapist assistants under the supervision of physical therapists are the only practitioners who have the education and training to give physical therapy services. Unqualified personnel should not be allowed to legally provide physical therapy services. Physical therapists are professionally educated at the college or university level in programs accredited by the Commission on Accreditation of Physical Therapy, an independent agency recognized by the U.S. Department of Education. As of January 2002, the minimum educational requirement to become a physical therapist is a post-baccaulaureate degree from an accredited education program. All programs offer at least a master's degree, and the majority will offer the doctor of physical therapy (DPT) degree by 2005.

In addition, the salary cap that will become active January 1, 2006 proposes immense limitations on the therapy received by Medicare patients. Once the ceiling payment is met, the rehabilitation services would have to be terminated. If personnel, other than physical therapists are allowed to perform physical therapy for patients, and the allotted charges tops out, the patients could have received treatment without ever having seen an actual physical therapist. Certainly, if personnel other than physical therapists bill the patient for providing physical therapy services, it is not truly physical therapy. Therefore, it is important that those most qualified to perform physical therapy, as mentioned previously by CMS in 42 CFR §484.4, should be the only ones allowed give these valuable services. Thank you for considering my comments.

Submitter : Miss. Amanda Crain **Date & Time:** 09/24/2004 02:09:57

Organization : Therapeutic Massage

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision

CMS-1429-P-3639

Submitter : Mrs. Victoria Boyd **Date & Time:** 09/24/2004 02:09:28

Organization : Mrs. Victoria Boyd

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

As a massage therapist treating many caes of pain and long-term discomfort per week, most of which were ineffectively treated prior with other methods by doctors and physical therapists, I implore you, do NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide the most effective and least invasive services to their patients with a physicians prescription or under their supervision. Many of my patients have gone years without relief, because insurance would not cover a treatment at the time that could have lessened or eliminated the cause of their pain, reciving instead medications that masked sypmtoms, treatments that were covered but didn't help, or surgery that was only marginally helpful. Often these people are/were unaware that they could live pain-free, that their problems could be fixed, because their doctor only prescribed what insurance would cover, and are amazed at the lasting results they recive from simple work they only recived via a loved one's gift.

Submitter : Ms. Kristina Carter **Date & Time:** 09/24/2004 02:09:44

Organization : UMDNJ, Newark

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Hello,

Here is a letter reguarding the "incident" to proposal issue.

Kristina Carter, SPT

Submitter : Mrs. Linda Mazzoli **Date & Time:** 09/24/2004 02:09:17

Organization : Cooper University Hospital

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

ASSIGNMENT

? Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have a bachelor?s or master?s degree from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master?s degree or higher. I am one of those with an advanced degree. This great majority of practitioners who hold advanced degrees are comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

? CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services. This is not what is best for the consumer. This is clearly a business issue.

? For the last 16 years I have worked within the outpatient rehabilitation sector treating physically active individuals at all age levels and professional levels. I did this day in and day out with a team of individuals with varying educational and experience back rounds. We had one common goal; to get our patients better. All of us (ATC, PT, OT, PTA, COTA, and SLP) did this under the guidance of the referring physician. Why is it different now?

? CMS does not have the statutory authority to restrict who can and cannot provide services ?incident to? at a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.

? These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent. I am asking that you please reconsider your proposed changes.

Sincerely,

Linda Fabrizio Mazzoli, MS, ATC, PTA, PES

THERAPY - INCIDENT TO

Linda Fabrizio Mazzoli,
MS, ATC, PTA, PES
Cooper Hospital, Bone & Joint Institute
3 Cooper Plaza
Camden, NJ 08103

September 22, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

? ?Incident to? has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician?s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician?s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

? There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY ?incident to? service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

CMS-1429-P-3642

Submitter : Miss. Tiffany Williams **Date & Time:** 09/24/2004 02:09:58

Organization : Miss. Tiffany Williams

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See Attached File

CMS-1429-P-3642-Attach-1.doc

Sue Stanley-Green
Athletic Training Program Director
Florida Southern College
Lakeland, FL 33801

September 19, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this will eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients, increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program, been utilized by physicians to allow others, under the physicians supervision, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered.
- There have never been any limitations or restrictions placed upon the physician in terms of who they can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under their care, Medicare and private payers have always relied upon the professional judgment of the physician to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide their patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals, it is likely the patient will suffer delays in health care, greater cost and a lack of access to immediate treatment.
- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers accompanied the U.S. Olympic Team to Athens this summer to provide these services to our top athletes. For CMS to even suggest athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This recommendation is a health care access deterrent.

Sincerely,

Sue Stanley-Green, ATC

CMS-1429-P-3643

Submitter : Dr. Robert Siegel **Date & Time:** 09/24/2004 02:09:18

Organization : Oncology Associates, PC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am an oncologist in greater Hartford, CT and part of a 7 physician practice. I have had the opportunity to meet with some representatives from CMS located in the Northeast region. I would reiterate in this comment as I have to them personally, that implementing the above revisions without appropriate trial and data is foolhardy.

Major Issues-

ASP does not represent what oncology practices pay for these drugs but rather is more indicative of the price to large volume distributors. The addition of 6% may at best make us "neutral" but in no way compensates for the business costs of acquiring storing and managing these drugs. Just because we are physician practices does not mean that we are free of the business issues of any small company maintaining an expensive inventory. ASP + 12% might more accurately reflect these costs.

The reduction of practice expense reimbursement will be a major loss to the practices. The AWP-15% factor currently in place for drug reimbursement on average covers the cost of the drugs. The practice expense reimbursement largely has been utilized to offset the costs associated with and unique to the provision of outpatient cancer care (disproportionately large office space for patient comfort for long term infusions, highly skilled chemotherapy nurses, bags tubing and other ancillaries uses for the infusion, volumetric pumps to minimize drug infusion errors, the hood for processing the meds, etc., etc. Without disparaging our internist colleagues, we run a more complex operation but are reimbursed largely from the same code book. If drug "margins" are eliminated (as I think they should) the there needs to be an alternative source of funding to pay for the very specific labor and technology-intensive services we provide.

We appreciate CMS' efforts to alow billing of 96408 each day for each chemo agent administered. However, nonchemo drugs administered via push technique involve the same resource consumption and I would ask that multiple billings for 90784 per day be allowed as well.

Similarly I would argue that "additional hours" be billable for each of multiple drugs used in a combination chemo regimen perhaps with a -59 modifier indicating a combination regimen.

The position of CMS that losses from the Medicare syustem will be potentially less than you are predicting because of more favorable payment systems in operation, presumably from private insurers, is laughable. Many of our HMO systems have already taken your AWP-15% program for drugs as a starting point and have conveniently foregone the increase in practice reimbursement expenses in 2004 built into the MMA. If anything, some of these groups are using Medicare guidelines as a ceiling for their reimbursements rather than a floor.

CMS has stated that these initiatives will not affect access to care. I beg to differ. Although we have no specific plans as of yet, I believe that this program has the potential to be disastrous. We cannot subsidize the cost of this care, and I am concerned that this will be the net result. If that is the case we will likely have to shift some patients to the hospital setting, a prospect not looked upon enthusiastically by my institution and/or we will have to pare staff limitng the efficiency of my office and disrupting what should be a caring and nurturing setting for therapy. I am not afraid to be reimbursed somewhat less for my services. The system is clearly in crisis. Implementing an untested and unproven program without any sense of its implications is the wrong approach. The system needs to be approached with a scalpel and not a sledge hammer.

As physicians are squeezed in an effort to lower the cost of cancer care, eliminating our "margins" and limiting our practice expense reimbursements will save some money only in the short run. Ultimately you will have succeeded in dismantling a successful system of outpatient oncology care but have done nothing about the real culprit-pharmaceutical costs.

CMS-1429-P-3644

Submitter : Mr. Arthur Roy **Date & Time:** 09/24/2004 02:09:28

Organization : National Athletic Trainers' Association- Member

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached document. Thank you.

CMS-1429-P-3644-Attach-1.doc

Arthur Roy, ATC
95 Winchell Drive
Kensington, CT 06037

September 23, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to any trained individual (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.
Sincerely,

Arthur Roy, ATC
95 Winchell Drive
Kensington, CT 06037

September 2004

The Coalition to Preserve Patient Access to Physical Medicine and Rehabilitation Services

The Centers for Medicare and Medicaid Services (CMS) published in the August 5, 2004 Federal Register, pages 47550-47551, a proposal that would limit reimbursement of physicians for "Therapy-Incident To" to a narrow group of providers: physical therapists, occupational therapists and speech and language therapists. Currently CMS regulations allow the physician the freedom to choose any qualified health care professional to perform therapy services at the physician's office or clinic.

We do not support this proposal or similar ones contained in the Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005 (CMS docket # 1429-P). We believe the provisions, which will restrict the physician's ability to determine the type of health care provider who administers "Therapy-Incident To" services, are poorly conceived and could have a detrimental effect on the welfare of Medicare patients.

Official Statement

We, the official representatives of the undersigned organizations, wish to formally state our position on Medicare's proposed changes to the "Therapy-Incident To" services. We believe the health and well being of the Medicare beneficiary should be the primary consideration. To this end, physicians and all other medical professionals authorized to order "Therapy-Incident To" services should have the continued medical authority to determine proper care and treatment for the patient and to select the best available, most appropriate health care professional to provide that care, including "Therapy-Incident To" services. A number of complex factors affect a physician's choice of the most appropriate health care professional to provide "Therapy-Incident To" services in his/her office or clinic. Some examples are type of medical practice; geographic location such as rural or medically underserved areas; availability of qualified allied health care personnel; and patient access to Medicare and secondary health care system providers. The physician is best equipped to make these medical decisions. We believe any attempt by government entities or other organizations to change this heretofore established right and purview of the physician clearly is not in the best interest of the patient.

We unequivocally request that no changes be made to Medicare or other provisions affecting "Therapy-Incident To" services reimbursement from CMS.

Sincerely,
Arthur Roy, ATC
Member of the National Athletic Trainers' Association.

CMS-1429-P-3645

Submitter : Mr. Joseph Carr **Date & Time:** 09/24/2004 02:09:02

Organization : Asso of bodywork and massage professionals, More

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I provide a much needed service to the patients of the Medical Doctors I work for. Medical massage within the present parameters focuses on pain management and range of motion, using hands on techniques that most Physical Therapists in my area are loath to use because the techniques are too time consuming and labor intensive.

Here are some interesting Q&A's I have heared, Q - Why don't you do the Massage and deep tissue work I do then you wont need me? A's - 1. I did'nt go to school for 8 years to give someone a massage, if they need it or not. 2. I have a 30 year career ahead of me and i'm not going to injure myself stretching some 250 lb aircraft mechanic. 3. I can't do what you do my hands and arms can't take it.

I see this as a lobbied change to protect the physical therapists job/ power. They wish to force out any profession that is encroaching on what they see as their Domain, when in fact the greater number of them would not perform the needed therapy themselves. Simply put I beleive they are afraid that some one will raise the bar, (And we are)forcing them to produce the work instead of continuing the billing mill practices they run now.

I have personally been a patient in a "Heat, Ultrasound, TENS.,Tredmill, Ice and bill 200+ dollars" facility. Then after becoming a Massage therapist I found myself working in one as an independant contractor with independant billing and protocols. I was replaced by 4 therapists who were assigned 7-9 min treatment windows and were billed out at 23 dollars per treatment. These are the people you are about to give near absolute control over patient recovery, and removing all other options for the recovery of their patients.

I am a Medically retired law enforcement officer, the oppertunity for fraud and embezzelment that would be created by granting exclusive right to all therapy to PT's, let alone the the Governmental Discrimination issues, would enevidably cause the repealing of the change.

Medical massage therapists are not just any bimbo slathering lotion most of us are well educated professionals.

If you want to increase the quality of therapy throughout the medical professions, create enforceable national licensure for medical massage therapists and othr crediblr CAM. providers. The reasoning is that most states PT.s are now have eather Masters degrees or Phd's PTA.s have bachulers degrees or equivilent certificates this leaves a large hole for up and coming group to fill namely Medical massage therapists.

Another reason not to make this change is that Complamentry alternitive medicine is a multi billion dollar industry that the federal government is soon to recognize needs to be paid for, and this change is just positioning to prevent those professionals from forceing the physical therapy profession to raise the bar in quality of therapy instead of over education.

Making this change would be criminal.....Joseph T. Carr, CMT.

Submitter : Gilbert **Date & Time:** 09/24/2004 02:09:23

Organization : AMTA, NCTMB

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care
providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

Submitter : PATRICIA MYERS **Date & Time:** 09/24/2004 02:09:11

Organization : PATRICIA MYERS

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I oppose this suggested regulation change.

CMS-1429-P-3648

Submitter : **Date & Time:** 09/24/2004 02:09:04

Organization :

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

SEE ATTACHED LETTER

CMS-1429-P-3648-Attach-1.doc

Brandie DuPont, MS, ATC
OSF St. Francis Hospital
3401 Ludington Street
Escanaba, MI 49829

September 22, 2004

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear CMS:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for Medicare patients as well as increase the costs associated with therapy services.

During the decision making process, please consider the following:

- "Incident to" has been utilized by physicians to allow trained individuals, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. This allows the physician the right to delegate the care of his or her patients to qualified therapy providers (including certified athletic trainers) and choose the provider who will best serve the needs of the patient.

- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy services elsewhere, causing significant inconvenience and additional expense to the patient. This may cause a delay in needed treatment for the patient.

- Patients who can currently be referred outside of the physician's office would incur delays in access of care. These delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to Medicare's medical expenditures.

- Also consider this: Certified athletic trainers are highly educated. ALL certified athletic trainers **must have a bachelor's or master's degree** from an

accredited college or university. Courses included in the completion of this degree include: human anatomy and physiology, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy percent of certified athletic trainers have a master's degree or higher. In this regard, athletic trainers are comparable to other health care professionals including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care providers. Athletic training academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), via the Joint Review Committee on education programs in Athletic Training (JRC-AT).

- To allow **only** physical therapists, occupational therapists, and speech and language pathologists to provide "incident to" outpatient therapy services would improperly give these groups exclusive rights to Medicare reimbursement. This would also improperly restrict states' rights to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services, including therapy services.

- Independent research has shown that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists. Because athletic trainers are well educated and competent, they are well able to work within their scope of practice when providing therapy services.

- Athletic trainers are employed by almost every post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to **prevent, assess, treat, and rehabilitate** injuries sustained during athletic competition. There is no reason why athletic trainers cannot provide these same services to a Medicare patient who becomes injured participating in a recreational activity with the same high standard of care.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed with regard to "incident to" services. Doing so would be a health care access deterrent for Medicare patients. Athletic trainers are experienced, skillful, dedicated health care professionals who are well qualified to provide cost effective therapy services to all patients, including those covered by Medicare.

Sincerely,

Brandie C. DuPont, MS, ATC

CMS-1429-P-3649

Submitter : Mark Brown **Date & Time:** 09/24/2004 02:09:46

Organization : Mark Brown

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

As a physical therapist who is required by Louisiana State Law and CMS Medicare reimbursement to possess a qualified education and licensure to provide services to patients who qualify for Medicare coverage, it is unfathomable that an individual of less education and licensure could provide the same levels of quality, professional care. Additionally, the level of physician supervision provided for non-qualified providers of physician outpatient physical therapy services is questionable.

The present process allows for a double standard in which the client/patient does not receive the same level of quality patient care in the physician outpatient services setting as required of outpatient services provided by physical therapists or physical therapist assistants supervised by physical therapists.

I believe that the revisions of the Medicare guidelines, specifically Medicare 'incident to' Physical Therapy Services, are appropriate and necessary to ensure quality patient physical therapy services and reduce the potential for fraudulent billing of physical therapy services by non-physical therapy providers.

Thank you for the opportunity to comment on this matter.

CMS-1429-P-3650

Submitter : Charles Peeples **Date & Time:** 09/24/2004 02:09:09

Organization : AMTA

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We oppose, and ask you to NOT pass this policy, obviously crafted by a lobby of medical "power-elite," whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

Submitter : Mr. Thomas LoCascio **Date & Time:** 09/24/2004 02:09:11

Organization : New Yrok State Society of Medical Massage Therapio

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Licensed Massage Theapists have MUCH more education and training in massage therapy than any other profession. In NYS we are required to take at least a 1000 hour course of study and pass a stringent licensing exam. Thanks for your time and consideration.

CMS-1429-P-3652

Submitter : Ms. Lisa Fischer **Date & Time:** 09/24/2004 02:09:29

Organization : N/A

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

To Whom it May Concern,

I was appalled when my massage therapist told me about this rule change to disallow anyone other than physical therapists to give care to patients! I am a patient who had both my tibia and fibula broken, a separated shoulder, and elbow gashed open when a local mayor hit me in his truck while I was walking in a cleary marked crosswalk, wearing a bright yellow coat. Although my physical therapists have helped me tremendeously with strengthening and range of motion issues, I would be in considerable greater pain if it weren't for the body work people, I see a massage therapist who employs a host of massage techinics as well as a reflexology/polarity therapist,I see them both on a regular basis (at first once a week and now twice a month). They have helped my hip, shoulder, back, neck, leg and soft tissue damage. Imagine what doesn't hurt on a human body after a truck has plowed into it! And all that pain cannot be simply addressed by physical therapists. Physical Therapists are important to one's recovery but so to are all the practitioners of massage therapy. Massage Therapists provide relief unavailable in the tradition American medical milleu. The world of western medicine plain and simply doesn't cut the proverbial mustard. It is high time that the government and insurance companies not only acknowledge, but accept, that we the consumers crave and are demanding more alternative choices in our healthcare that are thoroughly accepted, respected and covered by insurance. This rule change is disgusting at best and at worst, nothing more than the powerful and monied physical therapist association attempting to clear the field of what they, no doubt, consider competition for patients and market share. How interesting that I didn't know or find out about this rule change until the second to last day of the comment period. No coincidence I'm sure. As a state employee, I'm all too aware of how comment periods regarding rule changes are hardly covered by the news media and are usually buried in the back of newspapers!

CMS-1429-P-3653

Submitter : Ms. Phyllis Braun, LMT **Date & Time:** 09/24/2004 02:09:18

Organization : Heart of the Sun Healing Center

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I beg you NOT to pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physician's prescription or under their supervision. Massage therapy is proven to be a viable health care option for physician related prescriptions to help with pain and injury. Medical massage therapy is tried and proven to assist in the recovery and healing process. Thanks.

Submitter : Mr. Brian Hicks **Date & Time:** 09/24/2004 02:09:56

Organization : Mr. Brian Hicks

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

Issues 20-29

THERAPY - INCIDENT TO

Please see attachment

CMS-1429-P-3654-Attach-1.doc

CMS-1429-P-3654-Attach-1.doc

Brian K. Hicks
7213 Hannah Brook Road
Knoxville, TN 37918

September 23, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the

patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.

- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.

- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Brian K. Hicks ATC, CSCS

7213 Hannah Brook Road
Knoxville, TN 37918

CC: National Athletic Trainers' Association

CMS-1429-P-3655

Submitter : **Date & Time:** 09/24/2004 02:09:37

Organization :

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

Re: "Therapy Incident To"

I am writing in support of Centers for Medicare and Medicaid Services proposed requirement that physical therapy services only be provided and billed for by Physical Therapists and Physical Therapy Assistants if under the supervision of a licensed Physical Therapist. Physical Therapists are the only practitioners who have the unique education and training to furnish safe rehabilitation services. Our extensive knowledge of musculoskeletal anatomy, differential diagnosis, manual skills, and therapeutic exercise sets us apart from any other profession. This unique background enables physical therapists to obtain positive outcomes for individuals with disabilities and impairments. Physical Therapists are professionally educated in Universities accredited by the Commission on Accreditation of Physical Therapy, an independent agency recognized by the U.S. Department of Education. All programs offer at least a master?s degree, and the majority will offer the doctor of physical therapy (DPT) degree by 2005. The delivery of ?physical therapy services? by unqualified personnel is not only dangerous but insufficient for treating functional limitations and impairments.

Thank You. Your actions on this matter are very important for our profession and our population at large.

Sincerely,
SD
Senior Northeastern University Physical Therapy Student

Submitter : Ms. Karla Greenleaf-MacEwan **Date & Time:** 09/24/2004 02:09:42

Organization : Ms. Karla Greenleaf-MacEwan

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am oppossed to the policty to eliminate any provider except PT's from providing "incident to"medical professional's services to patients. Other trained professionals like massage therapists and acupuncturists can also provide valueable service. All qualified health careproviders should be allowed to provide services to patients with a physicians prescription or under their supervision.

Submitter : Ms. Carolyn Chanoski **Date & Time:** 09/24/2004 02:09:27

Organization : Ms. Carolyn Chanoski

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

Comments to CMS on Therapy??Incident to?

September 23, 2004

Dear Sir or Madam,

I am a physical therapist writing in support of the proposed ?Incident to? regulations for therapy.

Physical therapists have extensive training in the use of physical agents and therapeutic exercises. Minimum credentials for licensure as a physical therapist is a bachelor?s degree but many therapists have degrees at the master?s and doctoral levels. In most states, continuing education is required for physical therapists to maintain licensure as well.

I believe it is in the best interest of Medicare patients to have therapy services which are incident to physician?s services be provided by qualified personnel. There would be improved quality of care and fewer incidents of errors and injuries if qualified therapists were delivering these services.

The 1974 OIG report, ?Physical Therapy in Physicians Offices? outlined numerous abuses associated with services provided ?incident to? physicians? services. If services were provided by qualified therapists, if believe there would be a reduction of these abuses.

I urge you to adopt the regulation as proposed relating to ?incident to? services.

Thank you,

Carolyn Chanoski, PT

Issues 10-19

DEFINING THERAPY SERVICES

Comments to CMS on Therapy??Incident to?

September 23, 2004

Dear Sir or Madam,

I am a physical therapist writing in support of the proposed ?Incident to? regulations for therapy.

Physical therapists have extensive training in the use of physical agents and therapeutic exercises. Minimum credentials for licensure as a physical therapist is a bachelor?s degree but many therapists have degrees at the master?s and doctoral levels. In most states, continuing education is required for physical therapists to maintain licensure as well.

I believe it is in the best interest of Medicare patients to have therapy services which are incident to physician?s services be provided by qualified personnel. There would be improved quality of care and fewer incidents of errors and injuries if qualified therapists were delivering these services.

The 1974 OIG report, ?Physical Therapy in Physicians Offices? outlined numerous abuses associated with services provided ?incident to?

physicians? services. If services were provided by qualified therapists, if believe there would be a reduction of these abuses.

I urge you to adopt the regulation as proposed relating to ?incident to? services.

Thank you,

Carolyn Chanoski, PT

CMS-1429-P-3658

Submitter : Mrs. Alyson Pearson **Date & Time:** 09/24/2004 02:09:50

Organization : The Orthopedic Specialty Hospital

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please view attached letter. Thank you for your time in this matter.

Sincerely,

Alyson C. Pearson, MPH, A.T.,C.

CMS-1429-P-3658-Attach-1.doc

Via Electronic Mail—http://www.cms.hhs.gov/regulations/ecomments

Alyson C. Pearson, MPH, A.T.,C.
959 Spring Crest Ct. #21
Midvale, UT 84947

September 23, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

I am currently employed by The Orthopedic Specialty Hospital and Advanced Orthopedics and Sports Medicine as a Certified Athletic Trainer, located in Salt Lake City Utah. My position includes working with Primary Care Sports Medicine Physician Dr. James G. Macintyre, and Orthopedic Surgeon Dr. Lonnie E. Paulos. I work in their clinics providing patients with detailed home exercise programs, trained diagnostic testing for certain injuries, as a direct lesion between the physician, patient and the physical therapist, and as a high school Athletic Trainer. I have worked as a student trainer in the collegiate setting, and as a Certified Athletic Trainer in the 2002 Winter Olympic Games in Salt Lake. I also have the opportunity to work directly with Olympic Athletes on the US Speed Skating, Snowboarding, and Ski Teams. These athletes make up a small portion of the population that I have the privilege of treating and working with everyday.

The job description of an Athletic Trainer is to provide the Care, Prevention and Treatment of injuries. All of which includes physical therapy. Therapeutic exercises are necessary in any injury prevention program, as well as in all treatments to injury. Therefore a large portion of an Athletic Trainers time is spent instructing athletes of all ages and abilities in various physical therapy techniques. As athletic trainers we are required to take therapeutic exercise classes in school as well as participate in hands on training during internships and as student athletic trainers. We are just as qualified as Physical Therapy Assistance, who has only received a 2-year associates degree. Athletic

Trainers have bachelor degrees in Athletic Training and a large majority have gone on to receive a Masters degree in the health care field. To imply that we are not trained enough to treat the Medicare population is an insult to the time and dedication that I and my fellow Athletic Trainers have put into providing patients with the best trained and educated treatments available. Certified Athletic Trainers are also required to undergo 80 hours of continuing education during a 3-year period. Physical Therapist and Assistants are not required to meet these types of continuing education standards.

Having Certified Athletic Trainers in a clinical setting allow Physicians to provide their patients with a quick and timely treatment to their injury. We can give the patient a detailed Home Exercise Program in the office, which is tailored to fit their specific needs and abilities to assist in the healing process. Patients who are referred out to Physical Therapy Clinics may have to wait up to a week or longer to receive the care needed. This could be the difference in getting back on their feet in a few days versus a few weeks.

Individuals under the age of 65 are not the only ones who experience athletic related injuries. As our population continues to age so do the number of individuals over the age of 65 who are participating in various athletic events to stay fit. By limiting the types of medical professionals they can see for their injuries, Medicare will be lowering the standard of care that they claim they provide for their patients. Medical Doctors should be the ones making the decision as to who is qualified to treat their patients.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent. Please remember when you are making your final decision that there are a number of qualified individuals who are capable of providing physical therapy to Medicare patients. Thank you for your time in this matter.

Sincerely,

Alyson C. Pearson, MPH, A.T.,C.
959 Spring Crest Ct. #21
Midvale, UT 84047

Submitter : Mr. Robert DeJohn Jr **Date & Time:** 09/24/2004 02:09:22

Organization : Sports Physical Therapy of NY, PC

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

CMS-1429-P-3659-Attach-1.doc

Robert R DeJohn Jr., ATC
Area Sports Medicine Coordinator
Sports Physical Therapy of NY, PC
2540 Sheridan Drive
Tonawanda, NY 14150

September 23, 2004

Centers of Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and physical therapy clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these services. In turn, it would reduce the quality of healthcare for our Medicare patients and ultimately increase the costs associated with this service.

I have been working in an orthopedic outpatient physical therapy for the past twelve years. I have been the Area Sports Medicine Coordinator for the past five years. Sports Physical Therapy of New York, PC employs over thirty certified athletic trainers across New York State. These certified or licensed athletic trainers are highly educated and must have a bachelor's or master's degree from an accredited college or university. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT). Certified Athletic Trainers are recognized by the American Medical Association as allied health care providers.

Incident to has been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals including certified athletic trainers whom the physician deems knowledgeable and trained in the protocols to be administered. The physician accepts legal responsibility for the individual under his or her supervision. Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients. In many cases, the change to "incident to" services reimbursement would render the physician

Robert R DeJohn Jr., ATC
Area Sports Medicine Coordinator
Sports Physical Therapy of NY, PC
2540 Sheridan Drive
Tonawanda, NY 14150

unable to provide his or her patients with comprehensive, quick accessible healthcare. The patient would be forced to see the physician and separately seek therapy treatments elsewhere causing significant inconvenience and additional expense to the patient.

It has been a long-standing concern of the APTA that personnel who are unlicensed and have not graduated from an accredited physical therapy professional program furnish services in physicians' offices and those services are billed as therapy services under the Medicare program. Under the current policy it is possible for a high school student or another individual with no training in anatomy, physiology, neuromuscular reeducation or other techniques to furnish services in a physician's office without the physician actually observing the provision of these services. I personally feel outraged by this statement by the APTA. As mentioned earlier, certified athletic trainers are highly educated and must have a bachelor's or master's degree from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness and exercise physiology. Certified athletic trainers graduate with a bachelor's or master's degree where a physical therapy assistant graduate with an associate's degree. A physical therapy assistant can deliver this service but not a certified athletic trainer. I feel this to be ludicrous! Which healthcare provider would you want to deliver your therapy service? Over the past twelve years I have found that patients feel more comfortable with a highly skilled allied health care provider. This provider being a certified athletic trainer not physical therapy assistant.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. I sincerely hope that you will deeply consider the decision you are about to make and the potential affect that this will have on all parties involved by passing this proposal.

Thank you for your time and consideration.

Sincerely

Robert DeJohn Jr., ATC
Area Sports Medicine Coordinator
Sports Physical Therapy of NY, PC

CMS-1429-P-3660

Submitter : Mrs. Dana Austin **Date & Time:** 09/24/2004 02:09:20

Organization : Dana Austin Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the proposed personnel standards for physical therapy services that are provided "incident to" physician services in the physician's office. Interventions should be represented and reimbursed as physical therapy only when performed by a physical therapist or by a physical therapist assistant. I strongly oppose the use of unqualified personnel to provide services described and billed as physical therapy services. I feel this would be unsafe for the patients, and would misrepresent physical therapy to others, confusing the populace.
Thank you for your work on this. Sincerely, Dana Austin PT

Submitter : Mr. John Till **Date & Time:** 09/24/2004 02:09:25

Organization : National Athletic Trainers Association

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

John Tillery, ATC, LAT
PO Box 4049
Clinton, MS 39058

9/23/2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician?s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician?s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient. There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working ?incident to? the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
Patients who would now be referred outside of the physician?s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient?s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide ?incident to? services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide ?incident to? care in physicians? offices would improperly remove the states? right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing.
Athletic Trainers are employed by almost ever U S post-secondary educational institution with an athletic program to work with athletes to prevent, assess, treat and rehabilitate injuries sustained in athletics.For CMS to suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary is outrageous and unjustified.

These issues may lead to physician practices eliminating the number of Medicare patients they acccept.
In summary, it is not necessary for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,
John TIllery, ATC, LAT
Head Athletic Trainer

Submitter : Mr. MARK STONEROCK **Date & Time:** 09/24/2004 02:09:55

Organization : NATA

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY STANDARDS AND REQUIREMENTS

To Whom it may Concern:
As an Athletic Trainer of the past 16 years, I am appalled at the lack of judgement being used in regards to the latest proposed Medicare revisions. My level of education and experience have allowed me to successfully participate in the care of many Medicare recipients over the years.

Limiting the amount of care providers is not the answer. Providing the Medicare recipient with qualified, affordable care is. As certified athletic trainers, we are trained to provide an important link in the healthcare system. I am quite confident in my abilities, as well as the abilities of my constituents in this matter.

Limiting the ability for athletic trainers to participate in this area of care is more costly to the Medicare program and a hinderence to the patient's treatment options.

Thank you for your consideration in this matter.

Sincerely, Mark Stonerock, ATC

Submitter : Ms. Georgine Larsen **Date & Time:** 09/24/2004 02:09:42

Organization : Waynesboro Family Medical Associates

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please do NOT pass the policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care professionals should be allowed to provide services to patients with a physician's prescription or under their supervision no matter what state they practice in with or without a license since some states do not have licensing laws yet.

CMS-1429-P-3664

Submitter : Ms. Courtney Rosenbaum **Date & Time:** 09/24/2004 02:09:28

Organization : Ms. Courtney Rosenbaum

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

CMS-1429-P-3664-Attach-2.txt

CMS-1429-P-3664-Attach-1.doc

Attachment #3664 (1 of 2)

Courtney Rosenbaum
P.O. Box 72
Campbell Hall, NY 10916

September 23, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Courtney Rosenbaum

P.O. Box 72

Campbell Hall, NY 10916

Attachment #3664 (2 of 2)

Courtney Rosenbaum
P.O. Box 72
Campbell Hall, NY 10916

September 23, 2004
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012
Re: Therapy – Incident To
Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the

patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.

To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.

Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists. Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Courtney Rosenbaum
P.O. Box 72
Campbell Hall, NY 10916

Submitter : Ms. Carolyn Chanoski **Date & Time:** 09/24/2004 02:09:42

Organization : Ms. Carolyn Chanoski

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Comments to CMS on Therapy??Incident to?

September 23, 2004

Dear Sir or Madam,

I am a physical therapist writing in support of the proposed ?Incident to? regulations for therapy.

Physical therapists have extensive training in the use of physical agents and therapeutic exercises. Minimum credentials for licensure as a physical therapist is a bachelor?s degree but many therapists have degrees at the master?s and doctoral levels. In most states, continuing education is required for physical therapists to maintain licensure as well.

I believe it is in the best interest of Medicare patients to have therapy services which are incident to physician?s services be provided by qualified personnel. There would be improved quality of care and fewer incidents of errors and injuries if qualified therapists were delivering these services.

The 1974 OIG report, ?Physical Therapy in Physicians Offices? outlined numerous abuses associated with services provided ?incident to? physicians? services. If services were provided by qualified therapists, if believe there would be a reduction of these abuses.

I urge you to adopt the regulation as proposed relating to ?incident to? services.

Thank you,

Carolyn Chanoski, PT

Submitter : Ms. Patti Nieves **Date & Time:** 09/24/2004 02:09:16

Organization : Curative Pharmacy Services

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Being in the Hemophilia Community for the past 7 1/2yrs I have come to realize that this community is very much a tight knit community. When the community has to fight for what they believe they are in the forefront ready to be heard. This community has been hit hard economically, financially and spiritually. In the 80's it was the HIV and AIDS. Most recently, Hepatitis C. So where does it stop? When can we provide these families with support for the affects of this disease?

Since I personally service hemophilia patients and their families I have come to understand not only their hemophilia needs but their social economic needs. WE do NOT just provide factor for these patients. HTC's have continually commented that our work is so desperately needed especially in times of cutbacks that have occurred in the healthcare field. The shortage of social workers, intrepretors and liaisons between the doctors and nurses have impacted the quality of care for patients especially for hemophilia patients. Their care demands close contacts with physicians and their Hemophilia Treatments Centers. Also, the intrepreting piece to all this is due to the spanish speaking patients who do not have any extra income to provide their own intrepretors. Language barriers usually come in to play since there is a shortage of staff and personnel who speak spanish. Customers have continually commented on how they are extremely lucky to have someone to confide in and just "bounce things off of" if they are having a "bad day" with their son/daughter/husband/wife. We provide care that cannot be measured in dollars and cents. However, we, as a company and the customer has to depend on this in order to provide the quality of care that we are so familiar with and want to continue. Please understand that these proposed cuts in the factor reimbursement would be detrimental to our hemophilia community. Our future for these customers would be a huge change for them. WE need to start bringing back some of the compassion and heart to heart work that is so desperately needed in our healthcare field. Please do not add another burden to them. I urge you to to separate the add-on payment at $0.20 per unit. This community does not need another disappointment with their health issues.
I thank you for your time.

Patti Nieves
Sr.Customer Service Sales Representative

Submitter : Mrs. Stephani Dill **Date & Time:** 09/24/2004 02:09:21

Organization : Stephani Dill LMT

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please do not pass a policy which would allow patients to receive incident to care from only or specifically physical therapists. All qualified professionals should be allowed to provide services to patients with a physicians prescription or under supervision.
Thank You.

CMS-1429-P-3668

Submitter : Miss. Sarah Del Monaco **Date & Time:** 09/24/2004 02:09:27

Organization : University of Illinois at Chicago, student PT

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I am in strong support of the proposed change for the physician fee schedule for calendar year 2005 reguarding physical therapy services 'incident to' a physician. PT's are the only persons qualified to provide physical therapy services. Thank you.

CMS-1429-P-3668-Attach-1.doc

September 23, 2004

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Dear Mark B. McClellan, MD, PhD,

SUBJECT: MEDICARE PROGRAM; REVISIONS TO PAYMENT POLICIES UNDER THE PHYSICIAN FEE SCHEDULE FOR CALENDAR YEAR 2005

I am a doctorate of physical therapy student at the University of Illinois at Chicago. I am currently in my second year of this three year program. I am an active member in both the Illinois and American Physical Therapy Association. Recently, I learned that you were looking for public opinion on the August 5 proposed rule on "Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005." In the proposed rule individuals providing physical therapy services "incident to" a physician must be graduates from an accredited physical therapy program. I strongly support the proposed change. Physical therapists are highly trained professionals in the area of neuromuscular disorders. They also have specialized training in the use of assistive adaptive devices and other equipment. I believe that due to this specialized training they are the only persons who should be providing physical therapy services. If a patient/client in a physician's office were to receive "physical therapy" from an untrained person they would be at risk for falling and other injuries. This bad experience would increase their healthcare costs should they need treatment for this injury. It would also make them skeptical of further rehabilitation and physical therapy services in the future. The person who provided the services would also be at risk for law suits and other such repercussions from their actions. Therefore, I would once again like to state that I am highly in favor of the proposed change. I would like to see one additional item in the change as well. I would like to suggest that the change include only licensed physical therapists, because someone who has not yet received their license has not yet proven that they are ready to treat patients independent of the supervision of another licensed physical therapist. I would like to end by thanking you for the consideration of my comments in making this decision.

Sincerely,

Sarah M. Del Monaco, SPT

CMS-1429-P-3669

Submitter : Dr. Joseph Aiello **Date & Time:** 09/24/2004 02:09:42

Organization : Dr. Joseph Aiello

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I would like to comment on the proposal regarding ultrasound vein mapping in patients with chronic kidney disease. Simply, it is imperative that in order to increase the percentage of patients with fistulas in the US, veins need to be identified very early and preserved. The only way to do this in those patients who don't have visible cephalic veins is to ultrasound map both arteries and veins of the upper extremities. If CMS believes that it is not cost-effective to pay 100-200 dollars in order to move in this direction then they can continue to pay 10,000 dollars yearly to maintain AV grafts.

Limiting the provision of this service to surgeons who see the patient the week before they do surgery is absolutely ludicrous. Nephrologists can provide this service with the assistance of qualified RVT's. I will provide the best service for the patient with kidney disease if they are referred early enough and I am given the ability and opportunity to ensure that their dialysis access is properly planed.

I request that both arterial and venous mapping of the upper extremities is allowed and reimbursed. In addition it is extremely important that the nephrologist be allowed to provide this service as well as radiologists and others who are willing to devote time to this important aspect of our patient's care. Hopefully, expanding this option to providers other than the surgeon, "word will get out" to ohter primary practitioners that they should consider early referral of patients with CKD and think about the importance of vein preservation.

The Fistula First initiative is a brilliant idea and I thank you so much for moving in this direction. I hope that CMS sees the importance of trying to identify and preserve veins at the earliest time possible. I'm afraid that by not being able to do this our percentage of patients with autogenous AVF's will not increased dramatically.

Thank you for all of your hard work and allowing us in the renal comunity to vent.

Sincerely,
Joseph Aiello M.D.
Asheville NC

Submitter : Ms. Mary Korf **Date & Time:** 09/24/2004 02:09:41

Organization : NCBTMB

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Limitations to the practice of manual therapy to just those persons who are PTs is restrictive and places a severe limit to the scope of what can be done manually to help clients. Not everyone responds to PT or MT. Both are therapies that can be helpful in many but not all persons. I think that policies should be broad enough to include help for all people. Why start off with a policy which can't cover the most people? Keep the policy board to include all helpful therapies.

CMS-1429-P-3671

Submitter : Ms. Tali Serota **Date & Time:** 09/24/2004 02:09:48

Organization : Ms. Tali Serota

Category : Health Care Provider/Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therpists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

CMS-1429-P-3672

Submitter : allen **Date & Time:** 09/24/2004 02:09:16

Organization : allen

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a physical therapist and i highly oppose unlicensed personnel in physicians offices perform physical therapy. Physical therapy is not just applying heat, e stim, ultrasound and etc. which usually happen in physician offices' 'physical therapy treatment'. the enumerated modalities alone cannot be considered physical therapy treatment because these are only adjuncts to therapy. Physical therapy is actually the exercises+modalities that physical therapist provide. another point that we have to understand is that physical therapy includes education of the disease process making patient understand why each modality+exercise is needed(importance). How can u explain to the patient the disease process if u don't know the effects of these modalities/exercise physiologically and anatomically. its just sad that unqualifed personnel is able to charge physical therapy even though it is not done by physical therapist. They might say that it is supervised by a physician but the question is how can u see 50-80 patients per day seeing patients(doctors) and at the same time supervising 5-10 unqualified personnel seeing 80-100 patients per day providing physical therapy. COMMON SENSE REVEAL TO US THAT ALL THIS IS IS A MONEY MAKING SCAM. Imagine, physical therapy not provided by a physical therapist. Patients are always on the losing end of all these misrepresentations and only greedy physicians offic (benefit?$$$). Passing this bill will insure patients will get what they deserve, a physical therapist providing physical therapy. Imagine buying a rotten apple, all these go to waste. consumers are at the losing end. Another point we have to consider is that physical therapist went to school for about 6 yrs. only to be misrepresented by an unqualified person because they say they are 'supervised by the physician'. All these misrepresentation is just a degradation and disrespect to the physical therapy profession. For the people who will pass these bill 'PUT YOURSELF IN OUR SHOES, HOW WOULD YOU FEEL'.

CMS-1429-P-3673

Submitter : **Date & Time:** 09/24/2004 03:09:34

Organization :

Category : Physical Therapist

Issue Areas/Comments

Issues 10-19

THERAPY ASSISTANTS IN PRIVATE PRACTICE

Dear Administrator,

As a physical therapist, I strongly support CMS's proposal to replace the requirement that physical therapists provide personal supervision (in the room) of physical therapist assistants in the physical therapist private practice office with a direct supervision requirement. This change will not diminish the quality of the physical therapy services.

In our state, physical therapist assistants are licensed under state law, have attended a 2-year college level educational program, and have passed a licensure exam. Physical therapist assistants are supervised by physical therapists, but do not require in the room supervision to provide physical therapy interventions. The physical therapist/physical therapist assistant team works together to mange a client's care. The need for the physical therapist to be directly in the client's room when the physical therapist assistant is providing selected interventions is not needed. The team approach provides a means for consistent discussion regarding the clients intervention and progress. This team approach allows all involved to be aware of the client's needs and provides the client with excellent physical therapy services.

Thank you for considering this comment.

Issues 20-29

THERAPY - INCIDENT TO

I am writing this comment in response to the August 5 proposed rule on 'Revision to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005.' I am in support of the proposal in the rule that establishes qualifications of individuals providing physical therapy services 'incident to' a physician should meet personnel qualifications for physical therapy.

As a physical therapist, I have had training specific to providing physical therapy services, have sat and passed a licensure exam, and am required to keep abreast of evidenced based practice to maintain my license. Additionally, the physical therapist assistant under my supervision also has passed a licensure exam and has the education and training to furnish physical therapy services. Licensure provides a basis of protection to the client receiving physical therapy and ensures that the individual providing that physical therapy service has the knowledge needed to appropriately implement the intervention.

I strongly support CMS's proposed requirement that physical therapists and physical therapist assistants under the supervision of the physical therapist working in physicians offices be the personnel providing those physical therapy services. Unqualified personnel should not be providing physical therapy services. The client deserves to know that the personnel who have a license to practice physical therapy provide the physical therapy services they are receiving. I have frequently had clients and friends say, they have been receiving physical therapy services. When questioned it is determined that an unqualified person, who cannot explain the intervention nor assess the clients progress, is providing the intervention. That places the public at risk.

Please consider approving this proposed rule change.

Thank you for considering this comment.

CMS-1429-P-3674

Submitter : Julie **Date & Time:** 09/24/2004 02:09:27

Organization : Julie

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I know from personal experience that when unqualified persons provide "physical therapy" "incident to" a physician they are at risk for harm. It gives the qualified physical therapists a bad reputation when people pretend they are qualified/trained to provide these services. Physical therapists are professionals and should be the only professionals to provide physical therapy services to patients.

CMS-1429-P-3674-Attach-1.doc

September 23, 2004

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Dear Mark B. McClellan, MD, PhD,

SUBJECT: MEDICARE PROGRAM; REVISIONS TO PAYMENT POLICIES UNDER THE PHYSICIAN FEE SCHEDULE FOR CALENDAR YEAR 2005

I am the Vice President of a small graphic design company. I heard that you were looking for public opinion on the August 5 proposed rule on "Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005." In the proposed rule individuals providing physical therapy services "incident to" a physician must be graduates from an accredited physical therapy program. I would like to offer my support of this change. My mother is 89 years old, and recently she underwent a hip replacement surgery. While in recovery she went to her physician and was being given "physical therapy" in his office. She fell during this visit, and ended up in a nursing home for the last four months. This "physical therapy" was not provided by a licensed physical therapist or physical therapy assistant. I believe if it had been my mother may not have fallen, and would have been able to remain at home. Physical therapists are trained in graduate schools in physiology, kinesiology, therapeutic exercise, and many other sciences. I believe that they are the only persons who should be providing physical therapy. Therefore, I hope you will strongly consider making the proposed change so unlicensed physical therapists are not being paid for and harming patients when they are not clearly qualified to provide these services. Thank you so much for allowing me to give input into this matter, and for taking the time to read my comments. I know I am not a health professional, but from my personal experience it seems unfair that physicians should be able to bill for services given by individuals who are unqualified to provide those services. Thank you again.

Sincerely,

Julie

CMS-1429-P-3675

Submitter : Ms. Amber LaPointe **Date & Time:** 09/24/2004 02:09:17

Organization : The Bodhi Tree - Integrative Massage and Spa Thera

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

I absolutely oppose your thoughts on considering Massage Therapists to no be a vaild part of patient healing in a medical setting. I currently work as a Massage Therapist for a small Medical Center and the most frequently referred to form of therapy that our auto-accident patients (about 90% of our patients)say has helped them recover the most from pain, depression, tension, and discomfort is Massage Therapy. By no longer offering this service to the people who benefit by it would be terrible mistake.

Submitter : Dr. Lyna Morimoto **Date & Time:** 09/24/2004 02:09:09

Organization : Hawaii Acupuncture Association

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Due to a shortage of licensed Physical Therapists in the United States, LMTs, PTAs, OTs and aides provide needed assistance in the care of patients. To overburden PTs with all the therapies would jeopardize the care of the patient.

THERAPY STANDARDS AND REQUIREMENTS

Not all Physical Therapists are trained to do bodywork, massage therapy, hand therapy, etc. Many chose to stick with the exercise programs and depend on LMTs, PTAs, OTs, etc. to provide these other specialized therapies.
Each State has its own licensing and certification requirements that were created to protect the public from unprofessional conduct and untrained personnel. These specializations were created because there is a need for them. Do not try to "fix" something that is not broken.

Submitter : Miss. Julie Rose Latorre **Date & Time:** 09/24/2004 03:09:01

Organization : Miss. Julie Rose Latorre

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

September 23, 2004
To Whom It May Concern:
My name is Julie Rose Latorre. I am a second year graduate student of the Doctor of Physical Therapy program at the University of Medicine and Dentistry of New Jersey (UMDNJ). I am writing in regards to the proposed 2005 Medicare physician fee schedule rule which was published on August 5, 2004. I strongly agree and support the proposal that require a graduate of an accredited professional physical therapist education program, or one that has met educational requirements for foreign trained physical therapists, or an individual who has met certain grandfathering clauses to be required for providing physical therapy services in a physician?s office. As a physical therapy student, I am aware of the extent and enormity of knowledge that goes into providing physical therapy services. So much more goes into providing physical therapy than most people think. In order for patients to have a successful and safe rehabilitation, there are many factors that need to be taken into consideration. The rigorous and challenging curriculum of the program both in class and in the clinic shows how the profession demands their physical therapists to be professional, knowledgeable and competent to ensure proper care is given to patients. Allowing an unqualified individual to provide physical therapy services can have serious consequences for patients. By implementing this proposal, I believe that society is being protected from a potentially unsafe treatment for their problems requiring physical therapy services. This proposal is of great importance. Please consider implementing it.
Thank you,
Julie Rose Latorre, SPT

CMS-1429-P-3677-Attach-1.txt

Attachment # 3677

September 23, 2004

To Whom It May Concern:

My name is Julie Rose Latorre. I am a second year graduate student of the Doctor of Physical Therapy program at the University of Medicine and Dentistry of New Jersey (UMDNJ). I am writing in regards to the proposed 2005 Medicare physician fee schedule rule which was published on August 5, 2004. I strongly agree and support the proposal that require a graduate of an accredited professional physical therapist education program, or one that has met educational requirements for foreign trained physical therapists, or an individual who has met certain grandfathering clauses to be required for providing physical therapy services in a physician's office. As a physical therapy student, I am aware of the extent and enormity of knowledge that goes into providing physical therapy services. So much more goes into providing physical therapy than most people think. In order for patients to have a successful and safe rehabilitation, there are many factors that need to be taken into consideration. The rigorous and challenging curriculum of the program both in class and in the clinic shows how the profession demands their physical therapists to be professional, knowledgeable and competent to ensure proper care is given to patients. Allowing an unqualified individual to provide physical therapy services can have serious consequences for patients. By implementing this proposal, I believe that society is being protected from a potentially unsafe treatment for their problems requiring physical therapy services. This proposal is of great importance. Please consider implementing it.
Thank you,
Julie Rose Latorre, SPT

Submitter : Mr. Ajay Gupta, M.D. **Date & Time:** 09/24/2004 03:09:36

Organization : Fort Wayne Neurology

Category : Physician

Issue Areas/Comments

Issues 1-9

MALPRACTICE RVUs

Regarding Section 303, Malpractice is more expensive for providers that run infusion center and administer medications in the office. The administration codes need to be increased to include this expense.

PRACTICE EXPENSE

Comments for the Medicare Payment Advisory Commission (MedPAC)

Section 303 of the Medicare Modernization Act requires the Secretary to promptly evaluate existing drug administration codes for physicians' services to ensure accurate reporting and billing for such services,taking into account levels of complexity of the administration and resource consumption. The statute further specifies that the Secretary will use existing processes for the consideration of coding changes and, to the extent changes are made, will use the process to establish relative values for these services. The Federal Register?s proposed rule states that MedPac is seeking comments regarding the work value that goes into the administration of drugs.

Work value that goes into administering drugs in a physicians office for infusion may include the following: Supplies including but not limited to ? tubing, needles, cotton balls, tape, alcohol.
Each visit may also include patient assessment, monitoring for side effects and/or secondary infections, ordering and reviewing lab work up information. Patient?s phone calls in between treatments. Time and overhead involved in ordering, storing, inventory control, and preparation of the medications. Initial infusions also have extended time explaining and monitoring patients. Malpractice insurance is increased because of these treatments also.

We ask that the reimbursement for the administration of drugs be increased to include the above work and overhead expense that practices incur for these administrations.

We ask that CMS create a new CPT code for the initial infusion, because of all the increased work involved in beginning these treatments.

We ask that CMS allow Providers to bill the Chemotherapy administration codes base on the product being administered and not by the DX treated. The same work value and overhead expense goes into the preparation and monitoring of these drugs regardless of the DX. CPT codes are should describe the procedure performed, not the DX treated.

SECTION 303

E. Section 303 ? Payment Reform for Covered Outpatient Drugs and Biologicals.

106% of ASP.

We believe that it will be very difficult for providers to purchase drugs at or below the proposed rates discussed in this proposed rule. If providers are not able to purchase drugs at or below the proposed rates it may interfere with patients? treatments.

We have spoken to distributors and discussed ways that providers might be able to purchase product under 106% of ASP. Some options are as follows :

Group Purchasing Companies ? this was mentioned in the Federal Register also.
*Some issues with Group Purchasing is that they are not available to all providers and/or all areas.
*Group purchasing may also involve disclosing some proprietary information.
*Not all medications are available under Group Purchasing orders. The medications that we have a hard time purchasing, below Medicare?s reimbursement, can not be purchased through Group Purchasing companies below 106% of ASP.

Allowing Providers to Purchase products for Medicare Patient?s at a lower fee - This solution would help providers continue to treat Medicare patient?s but distribution companies worry about the implications if they sell products for Medicare patients at a different rate than non-Medicare patients. We would need CMS?s
direction on this possibility.

Provider Rebates to make up loss - Providers would send reports to manufacturer?s detailing the number of units used for Medicare patients and the Manufacturer could rebate providers only enough to make them whole. Again we would need CMS direction on this possibility, especially with the ASP reporting that is required of the Manufacturers.

Some products need to be mixed before they can be shipped. The mixing requires expensive equipment that the provider does not own. The mixing increases the distributors overhead expense, which he must pass on to the provider. Medicare?s ASP reimbursement does not take this into account and this expense must somehow be addressed. Example ? J9293 Novantrone, manufactured by Serono, is a chemotherapy drug FDA approved to treat MS (ICD-9 code 340).

We do not believe it is CMS? intent to interrupt patients care nor is it their intent to force providers into a loss situation. The proposed rule however if not changed can and will create these situations. Therefore, we ask that CMS consider options that will cover providers if they continue to treat patients at a loss.

v. Limitations on ASP

Section 1847A of the Act describes in detail the use of ASP payment methodology. Sections 1847B of the Act describes the Competitive Acquisition of outpatient drugs and biologicals. Section 1847A(a) (2) gives providers the option to elects section 1847B. When CMS was asked, during and Open Door Forum, if providers could elect Section 1847B per drug, CMS answered ?we don?t know?. CMS is in the process of developing this methodology and it will ?phase in? in 2006 as the Secretary determines appropriate. As providers we ask CMS to allow Section 1847B of the Act to be a per drug election.
We ask that if CMS?s reimbursement, for a specific drug under Section 1847A, is below a provider?s cost the providers be allowed to electing Section 1847B for that specific drug only.

CMS-1429-P-3678-Attach-1.doc

CMS-1429-P-3678-Attach-1.doc

CMS-1429-P-3678-Attach-1.doc

Fort Wayne Neurology
2622 Lake Ave
Fort Wayne, IN 46805
260-460-3100

Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTN – CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

September 22, 2004

RE: **CMS-1429-P**

To Whom It May Concern:

This letter is being sent as public comment regarding the Revision to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005. August 5th Federal Register's Proposed Rule **CMS-1429-P**.

Fort Wayne Neurology is a 10 physician Neurology practice in Fort Wayne, IN. Our neurology practice includes an infusion department that treats many different neurological conditions. We have struggled in the past to prevent interruptions in Medicare patient's care, because of Medicare's low reimbursement. We have worked with Medicare on local, regional and national levels to help keep Medicare informed that patient's care could be interrupted if Medicare cannot reimburse medications above cost. We have also worked with distributors and manufacturers to insure that we are purchasing medications as inexpensively as possible. It is not this practice's desire nor it's intent to interrupt a patient's care. This said, we cannot treat patients, on an ongoing basis, if Medicare does not cover the cost of supplying the medication.

We believe we are doing all we can do to purchase products at a reasonable price. We are looking to help Medicare understand the overhead included in providing these types of treatments, prevent any interruption of care, and show Medicare the value of having these treatments provided in our office.

Below are the sections we are addressing and the comments:

E. Section 303 – Payment Reform for Covered Outpatient Drugs and Biologicals.

106% of ASP.

We believe that it will be very difficult for providers to purchase drugs at or below the proposed rates discussed in this proposed rule. If providers are not able to purchase drugs at or below the proposed rates it may interfere with patients' treatments.

We have spoken to distributors and discussed ways that providers might be able to purchase product under 106% of ASP. Some options are as follows :

Group Purchasing Companies – this was mentioned in the Federal Register also.

*Some issues with Group Purchasing is that they are not available to all providers and/or all areas.

*Group purchasing may also involve disclosing some proprietary information.

*Not all medications are available under Group Purchasing orders. The medications that we have a hard time purchasing, below Medicare's reimbursement, can not be purchased through Group Purchasing companies below 106% of ASP.

Allowing Providers to Purchase products for Medicare Patient's at a lower fee - This solution would help providers continue to treat Medicare patient's but distribution companies worry about the implications if they sell products for Medicare patients at a different rate than non-Medicare patients. We would need CMS's direction on this possibility.

Provider Rebates to make up loss - Providers would send reports to manufacturer's detailing the number of units used for Medicare patients and the Manufacturer could rebate providers only enough to make them whole. Again we would need CMS direction on this possibility, especially with the ASP reporting that is required of the Manufacturers.

Some products need to be mixed before they can be shipped. The mixing requires expensive equipment that the provider does not own. The mixing increases the distributors overhead expense, which he must pass on to the provider. Medicare's ASP reimbursement does not take this into account and this expense must somehow be addressed. Example – J9293 Novantrone, manufactured by Serono, is a chemotherapy drug FDA approved to treat MS (ICD-9 code 340).

We do not believe it is CMS' intent to interrupt patients care nor is it their intent to force providers into a loss situation. The proposed rule however if not changed can and will create these situations. Therefore, we ask that CMS consider options that will cover providers if they continue to treat patients at a loss.

v. Limitations on ASP

Section 1847A of the Act describes in detail the use of ASP payment methodology. Sections 1847B of the Act describes the Competitive Acquisition of outpatient drugs and biologicals. Section 1847A(a) (2) gives providers the option to elects section 1847B. When CMS was asked, during and Open Door Forum, if providers could elect Section 1847B per drug, CMS answered "we don't know". CMS is in the process of developing this methodology and it will "phase in" in 2006 as the Secretary determines appropriate. As providers we ask CMS to allow Section 1847B of the Act to be a per drug election.

We ask that if CMS's reimbursement, for a specific drug under Section 1847A, is below a provider's cost the providers be allowed to electing Section 1847B for that specific drug only.

Comments for the Medicare Payment Advisory Commission (MedPAC)

Section 303 of the Medicare Modernization Act requires the Secretary to promptly evaluate existing drug administration codes for physicians' services to ensure accurate reporting and billing for such services, taking into account levels of complexity of the administration and resource consumption. The statute further specifies that the Secretary will use existing processes for the consideration of coding changes and, to the extent changes are made, will use the process to establish relative values for these services. The Federal Register's proposed rule states that MedPac is seeking comments regarding the work value that goes into the administration of drugs.

Work value that goes into administering drugs in a physicians office for infusion may include the following: *Supplies* including but not limited to – tubing, needles, cotton balls, tape, alcohol.
Each visit may also include patient assessment, monitoring for side effects and/or secondary infections, ordering and reviewing lab work up information. Patient's phone calls in between treatments. Time and overhead involved in ordering, storing, inventory control, and preparation of the medications. Initial infusions also have extended time explaining and monitoring patients. Malpractice insurance is increased because of these treatments also.

We ask that the reimbursement for the administration of drugs be increased to include the above work and overhead expense that practices incur for these administrations.

We ask that CMS create a new CPT code for the initial infusion, because of all the increased work involved in beginning these treatments.

We ask that CMS allow Providers to bill the Chemotherapy administration codes base on the product being administered and not by the DX treated. The same work value and overhead expense goes into the preparation and monitoring of these drugs regardless of the DX. CPT codes are should describe the procedure performed, not the DX treated.

<u>MMA's concern regarding quality of care</u>

The MMA is concerned with and does not want quality of care to be affected by the proposed changes. How ever if providers are forced into a loss situation we believe that accessibility and quality of care will be affected. This will force patients to either not receive treatment or have it in an outpatient hospital setting.

Patients that we treat are often receiving treatment for Multiple Sclerosis (MS). MS is a disease that affects the body as a whole, patients who are undergoing treatment need to be constantly accessed and monitored for changes. We have found that outpatient facilities do not have staff that is knowledgeable or trained in treating the DX of MS or familiar with handling the medication for this DX. This has affected out patients in the past. Patients complain that the timeliness of visits is poor and patients may have to receive treatments off schedule (which effects their health), Medications have been mishandled, overall care was poor, injection sites were sore. Patients that are treated in our office, are cared for by qualified and knowledgeable staff members, that are familiar with the patient and their history.

We ask that quality of care be addressed in pricing medication and creating new CPT code and/or additional work value being added to existing codes.

Feel free to contact me for any further questions or comments.

Sincerely,

Tami Hoffman
Ajay Gupta, M.D.

Submitter : Mr. Jonathan Mark Ferrara **Date & Time:** 09/24/2004 03:09:46

Organization : Florida State Massage Therapy Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer "incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

CMS-1429-P-3680

Submitter : Steve Ferraro **Date & Time:** 09/24/2004 03:09:17

Organization : ABMP

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Many times over the past few years I have heard from aptients that Physical Therapy did not work for them especially if there was soft tissue damage. PT's do not address this issue nver have never will.
We beg you NOT to pas this [policy whereby a Physician cam only refer "incident to" serveces to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

CMS-1429-P-3681

Submitter : **Date & Time:** 09/24/2004 03:09:55

Organization :

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a physical therapist practicing in New York State for 22 years, 17 of which have been in my own independent practice for 17 years. I wish to comment on the August 5 proposed rule to the above mentioned policy.

CMS in the proposed rule discusses establishing requirements for individuals who supply outpatient physical therapy services in physician's offices. According to this, individuals providing Physical therapy must be graduates of an accredited professional physical therapy program or the equivalent if educated outside the U.S. I am strongly in support of this requirement. Physical therapy licensure should be the required standard for the reimbursement of physical therapy services otherwise there is no assurance whatsoever that quality physical therapy services are being provided. Although there is some legality that prevents the agency from requiring licensure at least requiring appropriate education means that physical therapy services are being provided by those who are trained to provide such services and who are accountable to their profession standards and ethics.

Physical therapists and physical therapist assistants under the supervision of physical therapists are the only practitioners who have the education and training to furnish physical therapy services. Physical therapy education most of which is currently at a master's degree level and by 2005 at the clinical doctorate level, provides significant training in anatomy, physiology and pathology and comprehensive patient care experience. This training allows physical therapists to obtain positive outcomes for individuals with disabilities and other conditions or injuries needing rehabilitation.

Physical therapy training is a patient goal centered functional outcome discipline. This education and training is particularly important when treating Medicare beneficiaries. It assures that unnecessary or prolonged treatment will not accrue. I have heard of many examples of poor or detrimental treatment from patients of mine who have received treatment masquerading as physical therapy and billed as such but administered by non-physicat therapists before coming to my practice. One patient complained of only receiving hot packs and a 'canned' exercise program given to him on a sheet of paper. He said he was never instructed on how to do the exercises. They hurt his legs and back so he never did them. He was extremely thankful when after several sessions his back pain had subsided from being instructed in proper sitting and sleeping positions and by a specific 20 minutes exercise program which he became diligent in doing.

In order to provide physical therapy services which will produced desired outcomes, they should be provided by physical therapists and physical therapist assistants under the supervision of physical therapists. For this reason I support maintaining the proposal requiring the provision of these services by an individual who is a graduate of an accredited professional physical therapist education program or must meet certain grandfathering clauses or educational requirements for foreign trained physical therapists.

Thank you in advance for the opportunity to provide this statement and your consideration of my comments.

CMS-1429-P-3682

Submitter : Mr. Terry Nitsch **Date & Time:** 09/24/2004 03:09:35

Organization : National Athletic Trainers Association

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a licensed athletic trainer in the state of Nebraska. I have been practicing now for 12 years. It is my opinion that there is absolutely no reason to change the current policy regarding issues 20-29. Licensed athletic trainers bring a vast knowledge of anatomy, physiology, kinesiology, and rehabilitation to the medical world. I have seen articles from physical therapists that seem to feel that we are not 'qualified' to treat injuries. But they seem to feel that physical therapy assistants are 'qualified'.

I have worked in the clinical setting my whole 12 years in practice. I have worked very closely with PT's and PTA's. I can tell you that I have gotten along GREAT with them both. And I can agree with PT's that PTA's are qualified to treat these injuries. My disagreement lies with the statement that ATC's are not 'qualified' to treat injuries. I would ask you to analyze the programs that licensed athletic trainers go through to get their degrees. I would put it up to ANY PTA program in the country. We study anatomy and rehabilitation just as much, if not more, that PTA programs. PTA programs are 2 years in length. NATA programs are a minimum of 4 years.

I see the APTA concerned that our association is making great gains in the eyes of the general public. They are concerned that we may take money out of their pocket. That, in my opinion, is all this issue is about. DO NOT change this policy because they are leading you to believe that we are not 'qualified'. That is ridiculous.

Licensed athletic trainers have a lot of knowledge and can help a lot of people. Do not deny us the chance to continue serving the public.

Thank you for your consideration.

Terry Nitsch

CMS-1429-P-3683

Submitter : Miss. Darlene Worrell **Date & Time:** 09/24/2004 03:09:43

Organization : Miss. Darlene Worrell

Category : Other Health Care Provider

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am asking you to do not allow the proposed ruling or policy to go through or pass where you are planning to eliminate any health care provider to supply "incident to" physicians professional services. Physicians should be the ones to either prescribe to independent licensed or certified health care providers or to allow those of his choice to provide those services under his or her supervision.

Thank you!!
Darlene Worrell, licensed massage therapist, FL.

Submitter : Ms. Victoria Noble **Date & Time:** 09/24/2004 03:09:39

Organization : NCBTMB

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

We beg you to NOT pass this policy whereby a physician can only refer
"incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

CMS-1429-P-3685

Submitter : Dr. Serena Brewer **Date & Time:** 09/24/2004 03:09:21

Organization : Dr. Serena Brewer

Category : Physician

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

As a resident physician I oppose this policy whereby a physician can only refer
services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

Submitter : Kushtahn Adair **Date & Time:** 09/24/2004 03:09:20

Organization : LMT, NCBTMB, IMA

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I beg you to NOT pass this policy whereby a physician can only refer
"incident to" services to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physicians prescription or under their supervision.

CMS-1429-P-3687

Submitter : Mr. Steven Friebus **Date & Time:** 09/24/2004 03:09:26

Organization : National Athletic Trainers Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Physicians and athletic trainers often have a greater level of communication and work closer together than many other types of therapy providers. Certified Athletic Trainers have extensive education and training in evaluating and treating injuries to a wide variety of individuals. We are trusted and relied upon throughout the world to rehabilitate and return individuals to pre-morbid levels and beyond. The United States armed forces believes in the skills of Certified Athletic Trainers such that they are employed to keep the elite groups such as the SEAL's at peak health. Who better than a Certified Athletic Trainer to care for you, me, and our aging population than a Certified Athletic Trainer. Please see attached file.

CMS-1429-P-3687-Attach-1.txt

Attachment # 3687

Steven D. Friebus, M.Ed., A.T.C./L
2501 W. Natchez St.
Broken Arrow, OK 74011 September 23, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system. During the decision-making process, please consider the following:

Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

In many cases, the change to "incident to" services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

Patients who would now be referred outside of the physician's office would incur delays

of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician's ability to provide the best possible patient care.

To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.

Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists. Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Steven D. Friebus, M.Ed., A.T.C./L

Submitter : Mr. Frank Serafini **Date & Time:** 09/24/2004 03:09:19

Organization : Mr. Frank Serafini

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please do not limit American's options - we are all unique individuals
and more than one type of professional can provide their training and
talents to address a patients needs. Physicians should not be limited
to only referring 'incident to' services to Physical Therapists.
I feel that all qualified health care providers should be allowed
to provide services to patients with a physicians prescription or who are under a physician's supervision.

CMS-1429-P-3689

Submitter : Mrs. Barbara Wire **Date & Time:** 09/24/2004 03:09:16

Organization : none

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY TECHNICAL REVISIONS

I don't want PTs to be the only health care professional allowed to provide medically related care to phsician's patients. Massage therapy is valuable and needed.

CMS-1429-P-3690

Submitter : **Date & Time:** 09/24/2004 03:09:24

Organization :

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I do not believe that physicians should charge patients for physical therapy services. While physicians are knowledgeable about the human body and how it functions, physical therapists and physical therapists assistants are specifically trained in the rehabilitation of patients. Physicians spend much of their patient interaction time dealing with diagnosis and explanation of the injuries suffered. The PT/PTA is able to spend their whole session treating the injury. If physicians were to spend time rehabbing patients and being allowed to bill for it, then the quality of their other responsibilities would surely suffer. Please allow those who train and study for rehabilitation be the ones who actually do the rehab for patients.

CMS-1429-P-3691

Submitter : Mr. Doug Blackburn **Date & Time:** 09/24/2004 03:09:12

Organization : Whitworth Athletic Training Program

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

I feel that these revisions will only be bad news for both athletic trainers and medicare patients

CMS-1429-P-3691-Attach-1.doc

Centers for Medicare & Medicaid Services
Department of Heath and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

To Whom It May Concern:

As an athletic training student I have recently received reason for concern. This concern has been brought to my attention by a proposal to mandate that only physical therapists are qualified to provide physical medicine services to Medicare patients.

This proposal is an obvious effort to strip job opportunities away from athletic trainers. How do you justify such a blatant and offensive attempt? Athletic trainers have been able to work into clinical settings because they have the knowledge and abilities to provide physical medicine services. As an athletic training student I constantly work with injured athletes with the goal of returning the athlete back to competition at their original level of play. The goals of many of my classes are to teach me how injuries occur, how the body reacts to injuries, and how to aide the body in the healing and strengthening processes. Thus, to say that athletic trainer's are unqualified to provide therapy services under the supervision of a physician is not only false but absurd.

Another observation that has been brought to my attention is that a large number of patients in physical therapy clinics are athletes. Who in the medical field has a better understanding of athletes than athletic trainers? So not only are athletic trainers qualified to provide therapy services but in some cases are actually more qualified than a physical therapist. In closing, to pass this proposal would not only take jobs away from individuals who have proven themselves qualified, but would also hinder athletes who are patients in physical therapy clinics. Please do not cause hardship for innocent people simply to make the APTA happy, for the reason that it would be unjust as well as unfair.

Sincerely,

Doug Blackburn

Submitter : Ms. Elizabeth Haapanen **Date & Time:** 09/24/2004 03:09:32

Organization : Sweetwater Spa, Mendocino

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

PLEASE don't toss out our rights to work with or for medical doctors or chiropractors as massage therapists or to allow our family & friends toreceive professional health care in physician's offices from those otherthan physical therapists only. This policy would amke it so a physician could to refer 'incident to' services ONLY to physical therapists. All qualified health care providers should be allowed to provide services to patients with a physician's prescription or under their supervision. I have witnessed teh healing power of massage therapy and I don't think it, or cranio sacral theraphy have been given the credit they deserve as effective healing modalities. In an enlightened future time, all emergency units and wards will be staffed by massage and cranio sacral therapists, where impact to the patient is minimal, but the healing is induced.

THERAPY STANDARDS AND REQUIREMENTS

Cranio-Sacral Therapy should be added to the standards of health care.

CMS-1429-P-3693

Submitter : Scott Powderly **Date & Time:** 09/24/2004 03:09:23

Organization : Scott Powderly

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached comments

CMS-1429-P-3693-Attach-1.doc

Scott D. Powderly, A.T.,C.

8 Mycroft Court

Reisterstown, MD 21136

9/23/04

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012
Re: Therapy – Incident To

Dear Sir/Madam:

I am an Athletic Trainer writing to express my concern over the recent proposal that would limit providers of "Therapy-incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. It would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide patients with comprehensive health care. The patient would be forced to see the physician and separately seek therapy, causing significant inconvenience and additional expense.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working "incident to" the physician, it is likely the patient will suffer delays in care, greater cost and a lack of local, immediate treatment.
- Patients who would now be referred outside of the physician's office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but also cost time and travel expense. Delays would hinder the patient's recovery and/or increase recovery time, which add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement.
- CMS offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. This action could be construed as an unprecedented attempt by CMS to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to

the quality of services provided by physical therapists.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

It is not necessary or advantageous for CMS to institute the changes proposed, and I request that the change not be implemented. This CMS recommendation is a health care access deterrent.

Sincerely,

Scott D. Powderly, A.T.,C.

Submitter : Mr. Eric Streeter **Date & Time:** 09/24/2004 03:09:00

Organization : Decatur Memorial Hospital/NATA

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file.

CMS-1429-P-3694-Attach-1.doc

I am writing to express my concern over the recent proposal that would limit providers of “incident to” services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician’s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician’s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.
- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
- Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
- Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide “incident to” services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide “incident to” care in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.
- CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of physical therapy services.
- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of running in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

CMS-1429-P-3695

Submitter : Mrs. Erin Gooldy **Date & Time:** 09/24/2004 03:09:33

Organization : Mrs. Erin Gooldy

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See attachment for comments.

CMS-1429-P-3695-Attach-1.doc

Erin Gooldy, MS, ATC, SCAT
808 Cedar Break Court
Lexington, SC 29073

September 8, 2004

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1429-P
PO Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my reservation and concern over the proposal that would limit providers of "incident to" services in physician offices and clinics.

If this proposal is adopted, it would severely limit the ability of qualified health care professionals, such as certified athletic trainers, to provide important services to an ever growing aging population. It will further reduce the quality of health care services available to our Medicare patient population and ultimately increase the costs associated with this service.

When considering this proposal, please take these points into account:

- Certified athletic trainers are a highly educated group of health care providers. All certified and/or licensed athletic trainers must have a bachelor's or master's degree from an accredited college or university. Foundation courses include, but are not limited to: human anatomy and physiology, kinesiology and biomechanics, nutrition, acute care of injury and illness, as well as coursework in psychology, statistics, and research design.
- Athletic trainers have extensive classroom and practical experience in order to sit for the certification exam. Once certified, athletic trainers are required to maintain a certain level of continuing education (competence) in order to stay certified by the national body.
- *Over 70%* of all certified athletic trainers have a master's degree or higher. This is comparable to other mid-level health care practitioners, including physical and occupational therapists, and registered nurses.

- Academic programs for certified athletic trainers are accredited through the Commission of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).
- If professional athletic organizations make use of athletic trainers to care for the health and rehabilitation of their athletes, it makes even more sense to have these same qualified individuals available to provide therapy for the general population.
- With such a large organization of certified and licensed health care providers available, athletic trainers make it possible to care and advise many more patients than would otherwise be possible if therapy were limited to only one group of providers (ie: physical therapists). With the “baby boomer” generation and their parents living longer, more people are needed to provide care for the minor injuries that occur with active lifestyles. Athletic trainers can play a vital role in helping this group of people stay generally healthier and prevent the need for more intensive, expensive therapy.
- I have already witnessed first hand the decreased desire to accept more Medicare patients because of the already reduced reimbursement provided for rehabilitation. Further limiting access of care for such a large patient population can only wreak havoc on an already overburdened healthcare system.

In closing, it would not be at all advantageous for the CMS to institute such changes, and I sincerely hope that CMS reconsiders such evidence before moving forward.

Respectfully submitted,

Erin Gooldy

CMS-1429-P-3696

Submitter : **Date & Time:** 09/24/2004 03:09:35

Organization :

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am writing this letter to you in reguards to recent proposal, CMS-1429-P. This proposal would limit providers of "incident to" services in physical therapy clinics. If this is to pass it would eliminate well qualified health care professionals from providing much needed care to a population that is soon to grow in great numbers as the "baby boomer" population gets older. It would reduce the quality of health care given to our Medicare patients and ultimately increase the health care costs on a system that already needs healp in todays time.
I am a certified Athletic Trainer who went to school for 4 years as a Physical Therapist does. I obtained clinical observation hours needed to sit for my board of certification exam as a Physical Therapist has to. I sat for and passed my board certification exam like a Physical Therapist has to. I applied for and met the standards for my state license as a Physical Thepist has to. The NATA has mandated that each certified Athletic Trainer has to complete 80 hours of continuing education to have each Athletic Trainer current and up-to-date on the latest training practices. Physical Therapists do not need to have this in New York State. I have been a Certified Athletic Trainer for 9 years and have worked in physical therapy clinics treating Medicare patients for all of those 9 years. I know for a fact that I have made a considerable difference in the people's lives that I have worked with. To have this proposal changed would be a great blow to not only the Physical Therapists and the clinics that we as Athletic Trainers work in but ultimately the quality of care that is given to Medicare patients.
When lookig at this decision please consider the following:

The physician should continue to be the one to decide the best intrests of their patients. There have never been limitations or restrictions placed upon the physicians in terms of who he or she can utilize to provide ANY incident of service. The physician takes upon themselves legal responsibility for the service of their patients under their supervision. Medicare and other providers have always relied upon their professional judgement of the physicians to be able to determine who is qualified enough to give care to their patients.

CMS,in proposing this change, offers no evidence that there is a problem with the care given to Medicare patients that needs fixing. The NATA feels that this is being done to appease the intrests of a single professional association who would seek to see themselves as sole providers of therapy services.

CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit. In fact, this can be construed as an attempt by CMS at the behest of a specific type of health care professional, to seek exclusively as a provider of physical therapy services.

Independant reserch has demonstrated by certified Athletic Trainers is equal to the quality of service provided by Physical Therapists.

The CMS proposal only relates to the delivery of outpatient therapy services. These are exactly thoise services provided by certified Athletic Trainers. CMS proposes to establish minimum standards for individuals who can work "incident to" physicians. The proposed change would only qualify physical therapists to perform these services. As a Certified Athletic Trainer I find this to be extremely offending of the services that I work so hard to provide. I feel that the CMS is judging me unqualified to provide these therapy services. I am outraged as a professional care giver and feel that I am just as qualified as a physical therapist to provide therapy services to not only Medicare patients but anyone with an orthopaedic problem.

In summary, it is not necessary for the CMS to institute the changes proposed. The CMS recommendation is a health care deterrent.

Jamie Heffron, ATC, CSCS
Sports Physical Therapy of NY, P.C.

Submitter : Mr. Anthony Sandoval **Date & Time:** 09/24/2004 03:09:25

Organization : Mr. Anthony Sandoval

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See Attached File

CMS-1429-P-3697-Attach-1.doc

Sue Stanley-Green
Athletic Training Program Director
Florida Southern College
Lakeland, FL 33801

September 19, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician clinics. If adopted, this will eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients, increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- Incident to has, since the inception of the Medicare program, been utilized by physicians to allow others, under the physicians supervision, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered.
- There have never been any limitations or restrictions placed upon the physician in terms of who they can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under their care, Medicare and private payers have always relied upon the professional judgment of the physician to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
- In many cases, the change to "incident to" services reimbursement would render the physician unable to provide their patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
- This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals, it is likely the patient will suffer delays in health care, greater cost and a lack of access to immediate treatment.
- Curtailing to whom the physician can delegate "incident to" procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, will take away from the physician's ability to provide the best possible patient care.
- To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide "incident to" services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide "incident to" care in physicians' offices would improperly remove the states' right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
- CMS, in proposing this change, offers no evidence there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

- Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.
- Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers accompanied the U.S. Olympic Team to Athens this summer to provide these services to our top athletes. For CMS to even suggest athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured and goes to their local physician for treatment of that injury is outrageous and unjustified.
- These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This recommendation is a health care access deterrent.

Sincerely,

Sue Stanley-Green, ATC

CMS-1429-P-3698

Submitter : Mr. Vernon Arnold **Date & Time:** 09/24/2004 03:09:26

Organization : Mr. Vernon Arnold

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

It does not make sense with regard to patient welfare and needs, cost to benefit of services, or the advancement of healing alternatives that a physician should be limited, or stuck, to using only physical therapy for "incident to" services. With the many different modalities and methods there are to treat problems, limiting a doctor's choice to only P.T. is a big step in a backward direction.
I ask that you reject this policy that physicians be only allowed to refer "incident to" services to physical therapists.
Thanks
Vernon Arnold

Submitter : Ms. Rebecca Cooke **Date & Time:** 09/24/2004 03:09:05

Organization : Beyond the Body

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please do not pass a policy where a physician can only refer
'incident to' services to physical therapists. The physician should be able to prescribe and supervise the provision of services by all qualified health care providers.